

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>22-1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Wicomico</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>222 N. Blvd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <u>Joseph</u>		Middle <u>Thomas</u>		Last <u>Akin</u>		4. DATE OF DEATH Month <u>July</u>		Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17/1889</u>		9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Telephone Plant Superv.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTH PLACE (County & State, or foreign country) <u>Millington, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>John Akins</u>						14. MOTHER'S MAIDEN NAME <u>Anna Olivia Jones</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>W.W.#1</u>		17. INFORMANT <u>Mrs. Nettie L. Akins (Wife)</u> Address <u>222 N. Blvd. Salisbury, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 4221 DUE TO (b) <u>ASCVD - cerebral involvement</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>6 July</u> , 19 <u>66</u> , to <u>7 July</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7 July</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. Joseph Fitzgerald</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph Fitzgerald</u>						22d. ADDRESS <u>Medical Center Salisbury Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Millington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Millington, Maryland</u>					
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>						ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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Wilmington

Salisbury

Salisbury

SSS N. Blvd.

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Sept. 17/1966

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Wilmington, Maryland

Retired Telephone Plant Superv.

Anna Clara Jones

John Akina

Mrs. Nettie L. Akina (Wife) SSS N. Blvd.

Salisbury, Maryland

YES 4.4.41

Dr. Joseph E. Akina

Salisbury 11/1966 Wilmington Delaware Wilmington, Maryland

WOLLOMAN & COMPANY SALISBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8, 9 fill in 6579 8/6/66 mb

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>3 Days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>Wicomico</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Birzlie</i>		d. STREET ADDRESS <i>22-1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Henry P. Anderson</i>		4. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1966</i>		5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 12, 1876</i>		9. AGE (in years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maxland, Wicomico</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Thomas Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Emily Moore</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-07-3747</i>		17. INFORMANT <i>Robert C. Anderson Tyson, Mt.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion, Acute</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Longstanding, rt. leg.</i> DUE TO (c) <i>Arteriosclerotic Cardiovascular Disease</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Macular Degeneration</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 wks.</i>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1965</i> to <i>July 27, 1966</i> that (I) (we) last saw the deceased alive on <i>7/27/66</i> and that death occurred at <i>9:00</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Rufus S. Garner, Jr.</i>		22b. DATE SIGNED <i>7/28/66</i>		22c. PHYSICIAN'S NAME (Type) <i>RUFUS S. GARNER, JR.</i>		22d. ADDRESS <i>Birzlie, Md.</i>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. REC'D BY REGISTRAR <i>AUG 1 1966</i>		22g. REGISTRAR'S SIGNATURE <i>James J. ...</i>		22h. DATE <i>AUG 1 1966</i>		22i. LOCATION (City, town or county) (State) <i>Birzlie, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/30/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Birzlie Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Birzlie, Md.</i>		23e. FUNERAL DIRECTOR <i>Whitman, Birzlie, Md.</i>		23f. ADDRESS <i>Whitman, Birzlie, Md.</i>		23g. REC'D BY REGISTRAR <i>AUG 1 1966</i>		23h. REGISTRAR'S SIGNATURE <i>James J. ...</i>		23i. DATE <i>AUG 1 1966</i>		23j. LOCATION (City, town or county) (State) <i>Birzlie, Md.</i>	

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
10657														
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>23</u>									
3. NAME OF DECEASED (Type or print) First <u>Granville</u> Middle <u>W.</u> Last <u>Banks</u>					4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1966</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 24 1897</u>		9. AGE (In years last birthday) <u>68</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race Horses</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pittsville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>220 09 1927</u>					17. INFORMANT <u>Mrs. Frances Hearn, Berlin, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma - primary site</u> <u>1992</u> DUE TO (b) <u>undiluted</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>App-10 mo</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) _____ (County) _____ (State) _____														
21. I certify that (I) (this hospital) attended the deceased from <u>7-8-1966</u> to <u>7-9-1966</u> , that (I) (we) last saw the deceased alive on <u>7-9-1966</u> , and that death occurred at <u>6:50</u> M, from the causes and on the date stated above.										22b. DATE SIGNED				
22a. SIGNATURE <u>James R. Coffey</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) <u>James R. Coffey</u>					22d. ADDRESS <u>Medical Center Salisbury Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>7-13-66</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>				
23d. LOCATION (City, town or county) _____ (State) _____														
24. FUNERAL DIRECTOR <u>Norman E. Hearn, Snow Hill, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
DATE <u>JUL 12 1966</u>														

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RECEIVED BY THE DIRECTOR

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[Faint, illegible handwritten text covering the majority of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1D <u>22</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>710 Venus St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>BECKETT</u> Last <u>BECKETT</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1966</u>				5. SEX <u>MALE</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 2, 1903</u> 9. AGE (in years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Wicomico</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>				13. FATHER'S NAME <u>Thomas Beckett</u> 14. MOTHER'S MAIDEN NAME <u>unk.</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>28</u> 17. INFORMANT <u>Paul Beckett</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>7/10</u> , 19 <u>66</u> , to <u>7/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/12</u> , 19 <u>66</u> , and that death occurred at <u>4:45</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>William B Smith</u> 22b. DATE SIGNED <u>7/12/66</u>											
22c. PHYSICIAN'S NAME (Type) <u>William B Smith</u>				22d. ADDRESS <u> </u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL-CREMATATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-17-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Talks Rd</u> 23d. LOCATION (City, town or county) <u>Talks Rd Md</u> (State) <u> </u>				24. FUNERAL DIRECTOR <u>Doan Devet</u> ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>JUL 19 1966</u>											

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1014 Cecil Street				d. STREET ADDRESS 1014 Cecil Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle Ernest Last Blake				4. DATE OF DEATH Month July Day 24 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1891	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 4		IF UNDER 24 HRS. Hours 4 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office manager				10b. KIND OF BUSINESS OR INDUSTRY Steam Ship Line		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Andrew Blake				14. MOTHER'S MAIDEN NAME Mary Lloyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louise Blake	
				1014 Cecil Street Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction							
DUE TO (b) Coronary atherosclerosis							
DUE TO (c) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary pectoris							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from Aug. 1966 to 7/24/66 , that (I) (we) last saw the deceased alive on 7/24/66 , and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Allen B. ...</i>				22b. DATE 7/25/66		22c. PHYSICIAN'S NAME (Type) Thomas F. Wallace	
22d. ADDRESS Salisbury, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 27, 1966		23c. NAME OF CEMETERY OR CREMATORY Valhalla Burial Park Staten Is., NYC., NY.	
23d. LOCATION (City, town, or county) _____ (State) _____							
24. FUNERAL DIRECTOR'S SIGNATURE Thomas F. Wallace				25a. REC'D BY REGISTRAR JUL 27 1966		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10022

RECEIVED

10022



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

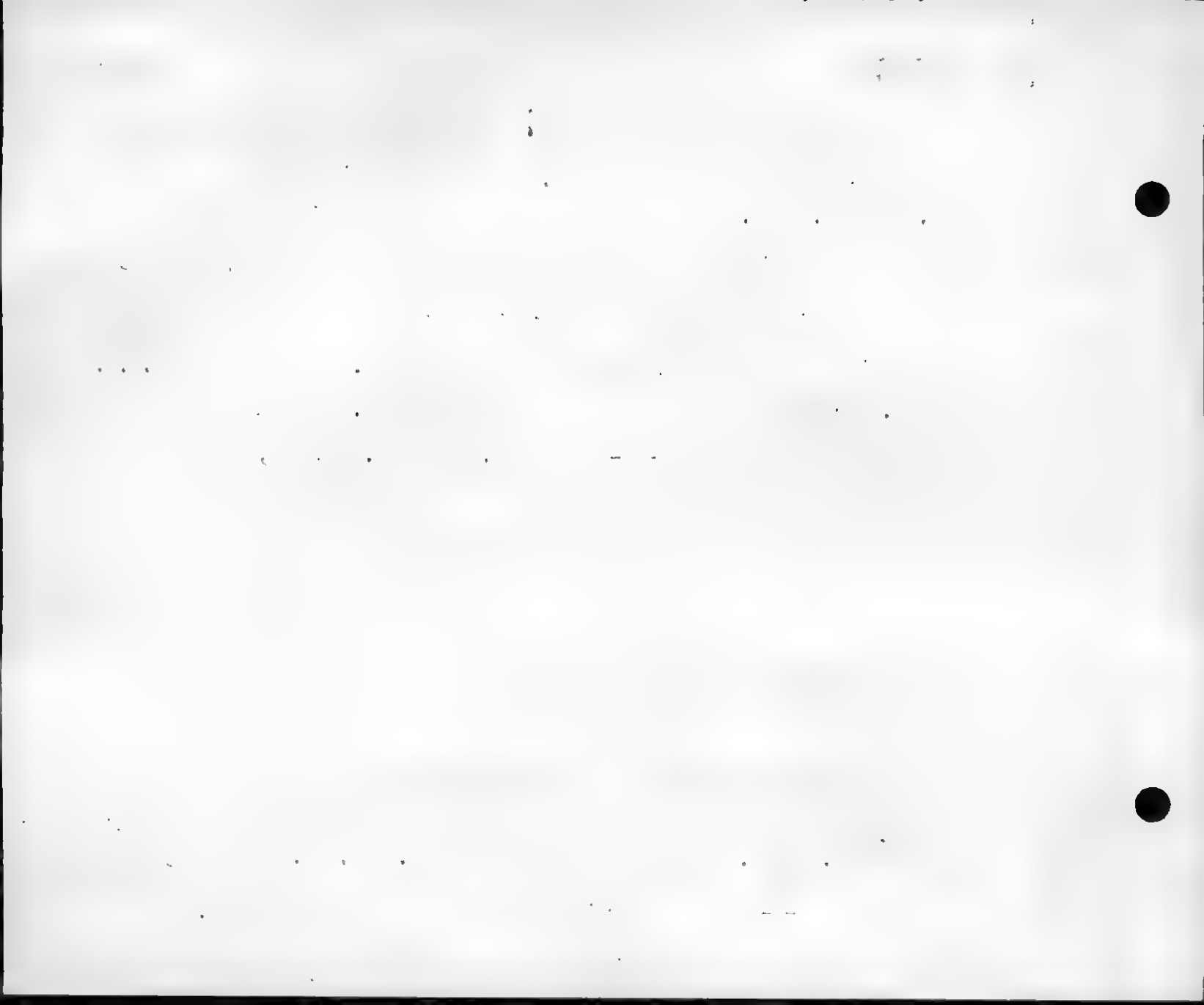
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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 4 Film 500 7/12/66 mh

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b 18 Mons.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sp. Hill Pr. Sani.		d. STREET ADDRESS 12 th At Bay	
3. NAME OF DECEASED (Type or print) First IRENE Middle MAE Last BOWSER		4. DATE OF DEATH Month 7 Day 5 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 5, 1897
9. AGE (In years with birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Altoona Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam B. Schuler		14. MOTHER'S MAIDEN NAME Rebecca B. Yingling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 210-12-3311	
17. INFORMANT Mrs. George W. Feehley, Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) this hospital attended the deceased from 1-6-65 , 19 65 , to 7-6-66 , 19 66 , that (1) (we) last saw the deceased alive on 7-5 19 66 , and that death occurred at 6A M, from causes and on the date stated above			
22a. SIGNATURE Dr. Lee L. Lawry		22b. DATE SIGNED 7/6/1966	
22c. PHYSICIAN'S NAME (Type) Dr. Lee L. Lawry		22d. ADDRESS 315 N. Div. St. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-8-1966	23c. NAME OF CEMETERY OR CREMATORY FairView Cemetery	23d. LOCATION (City or Town) (County) (State) Altoona, Pa.
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE JUL 8 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

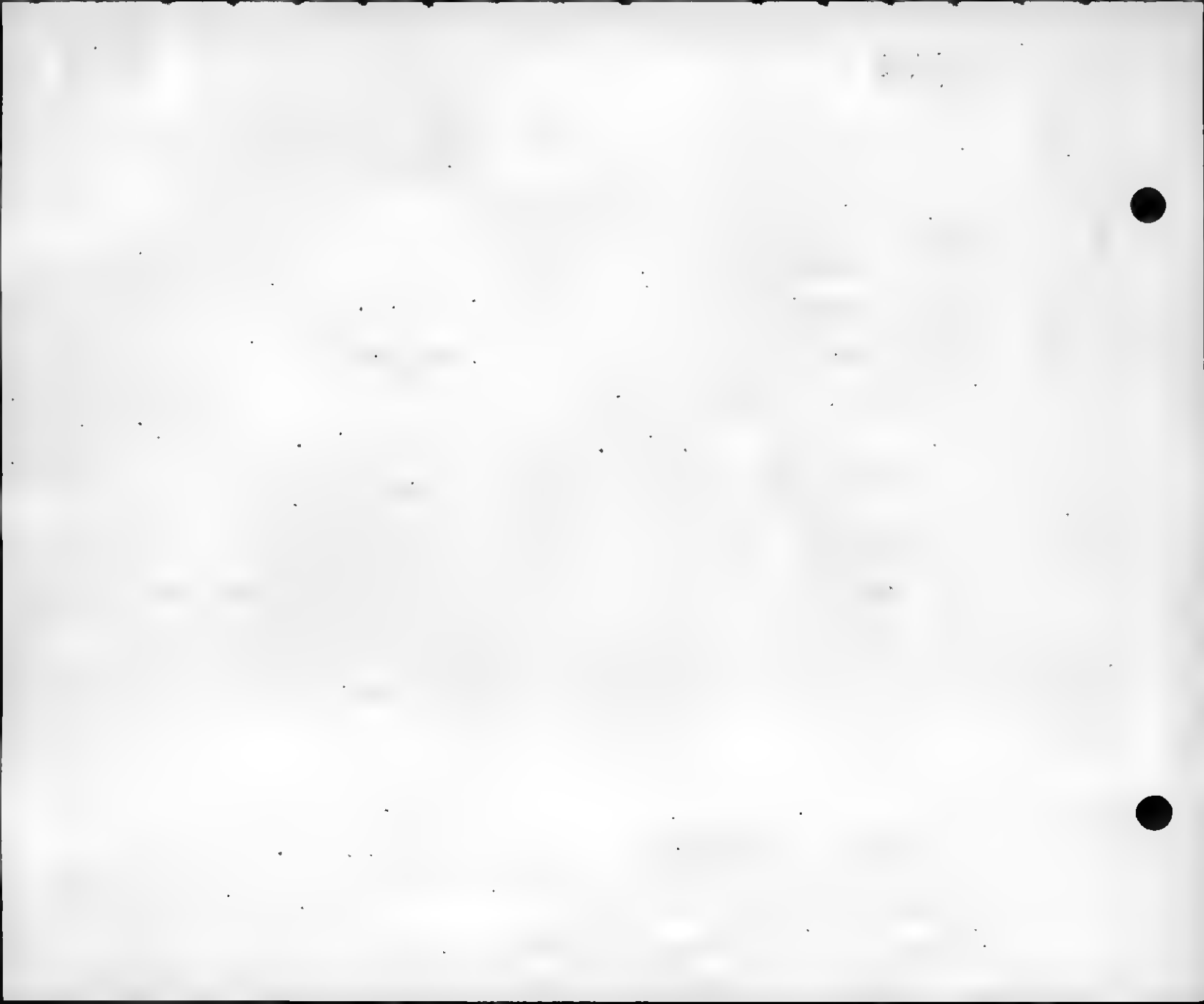


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10654

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. LENGTH OF STAY IN 1b <u>1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL</u>						d. STREET ADDRESS <u>102 EAST</u>					
3. NAME OF DECEASED (Type or print) <u>James N Brittingham</u>						4. DATE OF DEATH <u>July 17 1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-8-1908</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRAKE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SALISBURY-MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W. BRITTINGHAM</u>						14. MOTHER'S MAIDEN NAME <u>NETTIE FISHER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-10-7570</u>		17. INFORMANT <u>ERMA BRITTINGHAM</u> Address <u>DELMAR</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/10</u> , 19 <u>66</u> , to <u>7-16</u> , 19 <u>66</u> , and that death occurred at <u>1:35</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>N. W. Todd</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-17-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>N. W. Todd</u>				22d. ADDRESS <u>Medical Center Salisbury Del.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7-20-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST STEPHENS</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR-DEL</u>			
24. FUNERAL DIRECTOR <u>Charles W. Marshall</u>				ADDRESS <u>Delmar Del.</u>		25a. REC'D BY REGISTRAR <u>J. J. Jones</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Jones</u>			
						DATE <u>JUL 18 1966</u>					



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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kingston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home for Aged		d. STREET ADDRESS 17	
3. NAME OF DECEASED (Type or print) Margie Anna Broughton		4. DATE OF DEATH July 28 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1884
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Beale		14. MOTHER'S MAIDEN NAME Mary F. Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT John B. Parsons Home for Aged		Address Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Crown Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease DUE TO (c) year		INTERVAL BETWEEN ONSET AND DEATH year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-10 1966 , to 7-28 1966 , that (I) (we) last saw the deceased alive on 7-26 1966 , and that death occurred at 11 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Earl E. Royer		22b. DATE SIGNED 7-28-66	
22c. PHYSICIAN'S NAME (Type) EARL E. ROYER, M.D.		22d. ADDRESS 409 CAMDEN AVE. SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 30, 1966	
23c. NAME OF CEMETERY OR CREMATORY Rehobeth Pres. Church Cem.		23d. LOCATION (City, town, or county) (State) Rehobeth Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas F. Wallace		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Salisbury, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE AUG 1 1966			



VR AIS (4)
20M 1/65

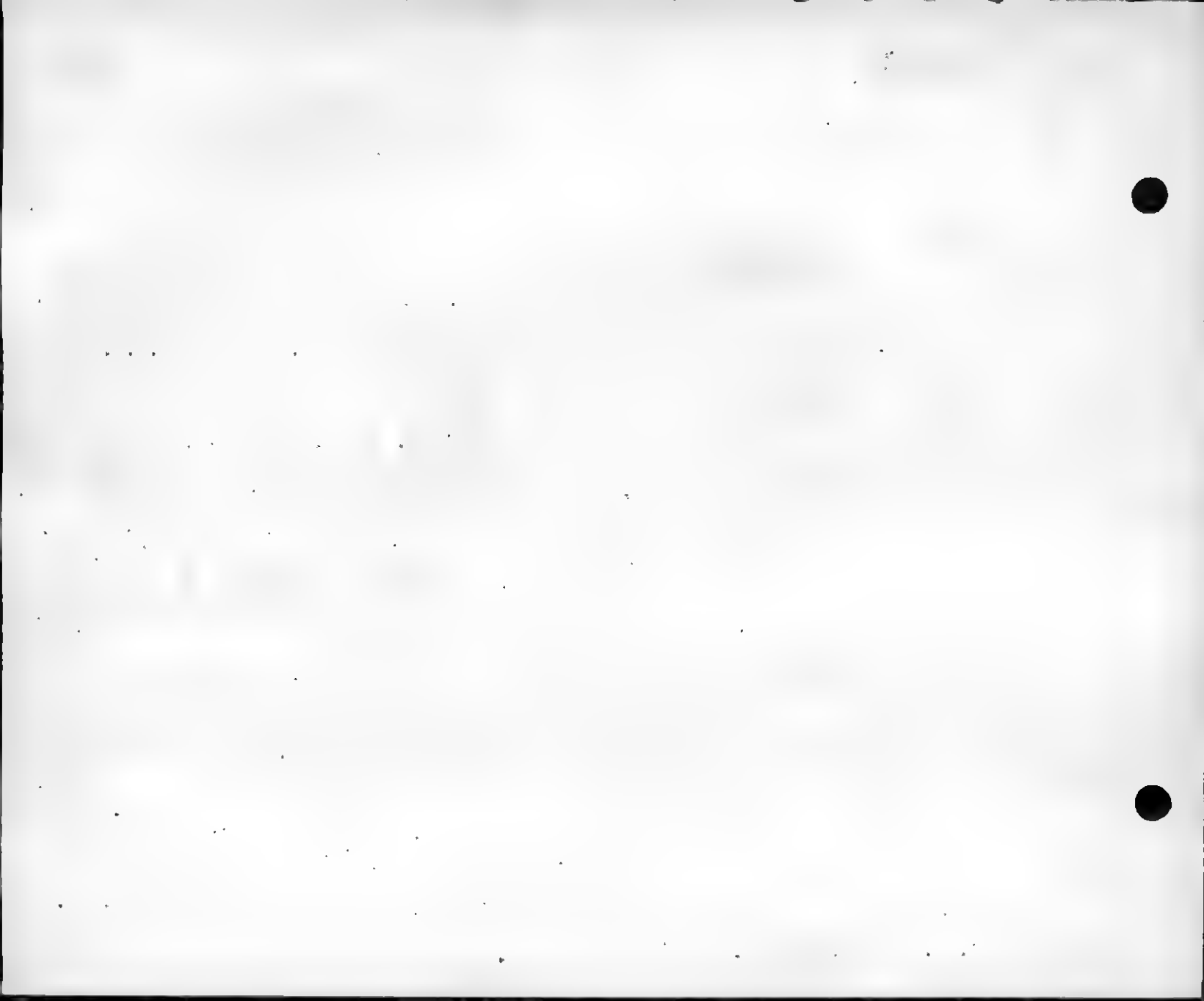
22

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALIS BURY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharptown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary First Sedonia Middle BROWN Last		4. DATE OF DEATH JULY 24 1966		Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1905	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) New Orleans, La.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Benjamin L. Brown, Sharptown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Marked Pulmonary Edema DUE TO (b) Congestive Cardiac Failure DUE TO (c) Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Coronary Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Don Beckling housewife			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sharptown, Md.	
20f. (City or town) (County) (State) Sharptown, Md.		21. I certify that (I) (this hospital) attended the deceased from July 22, 1966 to July 24, 1966 , that (I) (we) last saw the deceased alive on July 24, 1966 , and that death occurred at 9:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE G. Herbert Sembley		22b. DATE SIGNED 7/24/66		22c. PHYSICIAN'S NAME (Type) G. Herbert Sembley	
22d. ADDRESS Salisbury Rd		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 27, 1966		23c. NAME OF CEMETERY OR CREMATORY Thompstontown Cemetery	
23d. LOCATION (City, town or county) (State) Near East New Market, Md.		24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalburg, Md.			
25a. REC'D BY REGISTRAR JUL 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

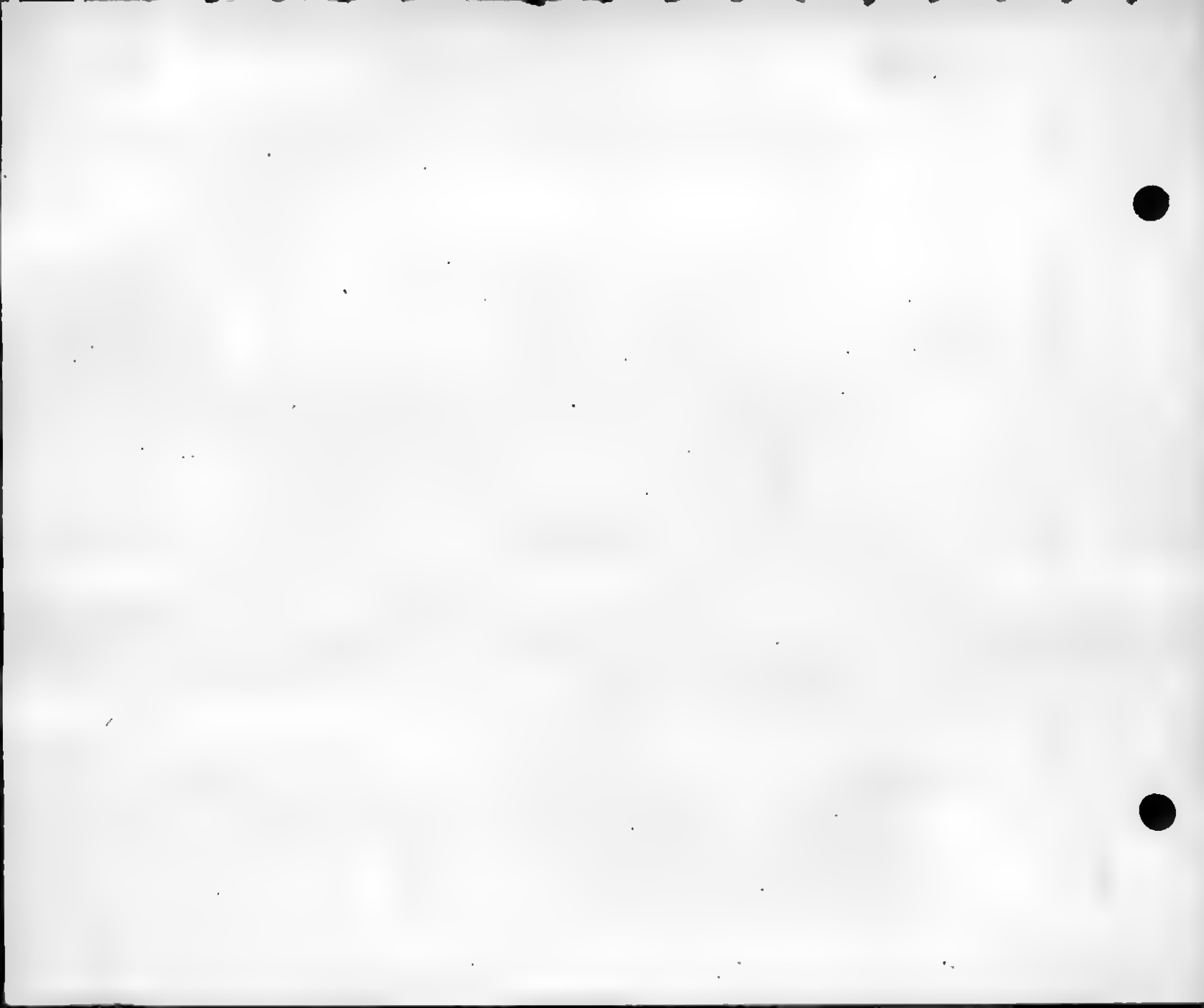
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Pocomoke Road</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>BRYANT, Jr.</u> Last <u>BRYANT, Jr.</u>		4. DATE OF DEATH <u>JULY 11 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1896</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barrel Hooper</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Bryant, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Rose Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-20-3598</u>	
17. INFORMANT <u>Mary Ellen Walls</u>		Address <u>6 Baytown St. So. Norwalk, Conn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATOMA</u> DUE TO (b) <u>NUTRITIONAL CIRRHOSIS</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> , 19 <u>66</u> , to <u>7/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/11</u> , 19 <u>66</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>D. M. Barrick</u>		22b. DATE SIGNED <u>7/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. M. BARRICK</u>		22d. ADDRESS <u>Peninsula General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-16-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Bapt. Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md.</u>
24. FUNERAL DIRECTOR <u>James L. [Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY MD</u> d. STREET ADDRESS <u>HASTINGS-MIRMAR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NORA</u> First <u>G.</u> Middle <u>CAPT</u> Last	4. DATE OF DEATH <u>July 28 1966</u> Month <u>July</u> Day <u>28</u> Year <u>1966</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>AUG. 24 1887</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>LONG BRANCH N.J.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>DR. EDWARD GIFFIN</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA MAC CREADY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>455-03-9950</u> 17. INFORMANT <u>MRS. MILTON CONNER</u> Address <u>OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema.</u> DUE TO (b) <u>Hypertensive L.V. failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>6 months.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/27/1966</u> to <u>7/28/1966</u> , that (I) (we) last saw the deceased alive on <u>7/28/1966</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Oswald Burton</u>		22d. ADDRESS <u>Medical Center - Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>	23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u> Address <u>Berlin Md.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>AUG 3 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

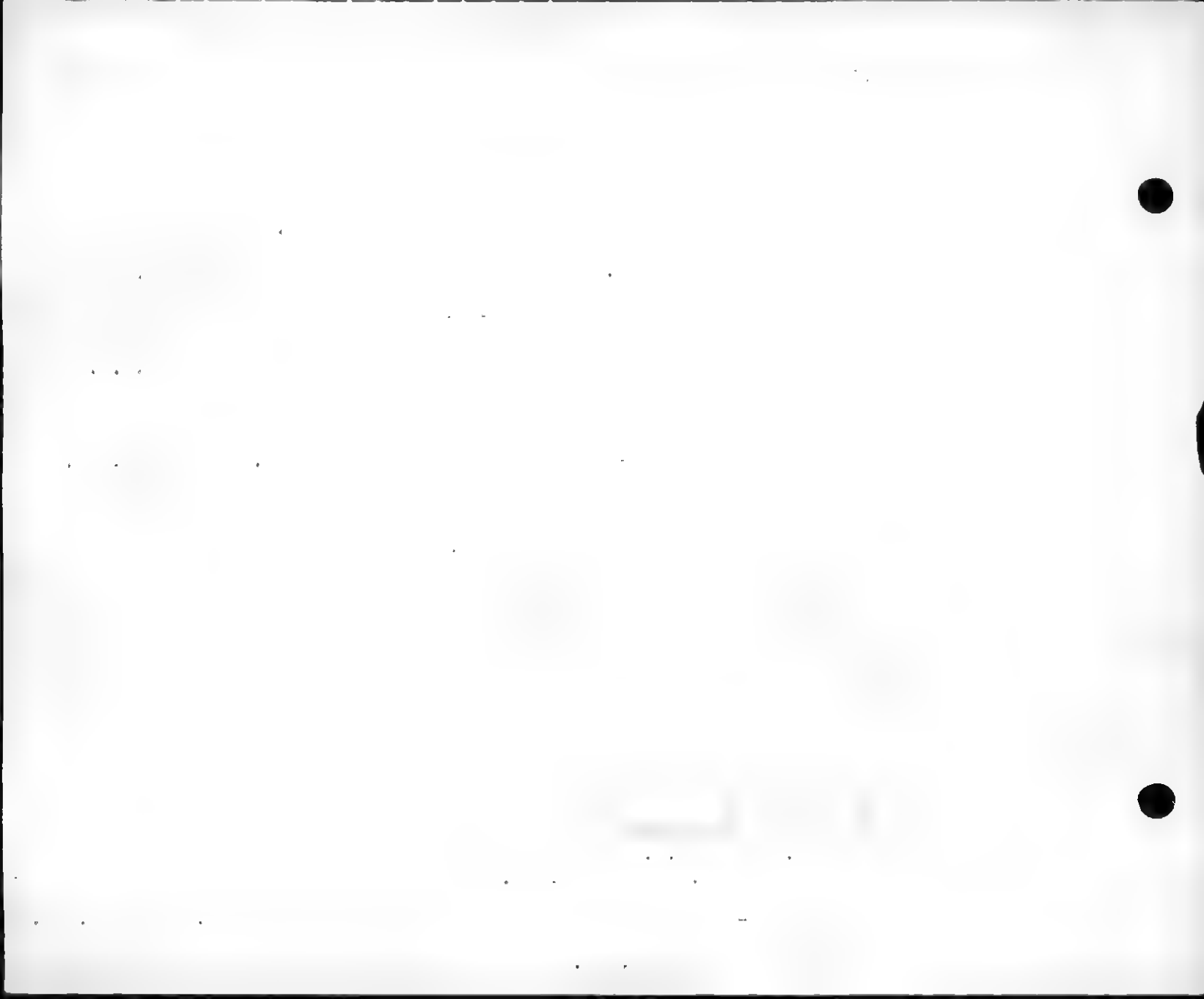
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 524 Rose St.	
3 NAME OF DECEASED (Type or print) First MARY Middle E. Last CARTER		4 DATE OF DEATH Month July Day 14 Year 1966	
5 SEX Female	6. COLOR OR RACE AA	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-12-1929
9 AGE (In years last birthday) 37 yrs		10 IF UNDER 1 YEAR Months 37 Days 37 Hours 37 Min 37	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Garfield Dashiell		14 MOTHER'S MAIDEN NAME Erma Hitch	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214-28-8783	
17 INFORMANT Willie Carter, Rose St., Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral edema 5711 DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) Fatty degeneration of liver stating the underlying cause last. (c) Chronic alcoholism		INTERVAL BETWEEN ONSET AND DEATH hours year year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 7-26-66	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7-19-66	23c NAME OF CEMETERY OR CREMATORY Green Acres	23d LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Md.
24 FUNERAL DIRECTOR Clinton Stewart, Salisbury, Md.		25a RECD BY REGISTRAR DATE AUG 1 1966	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

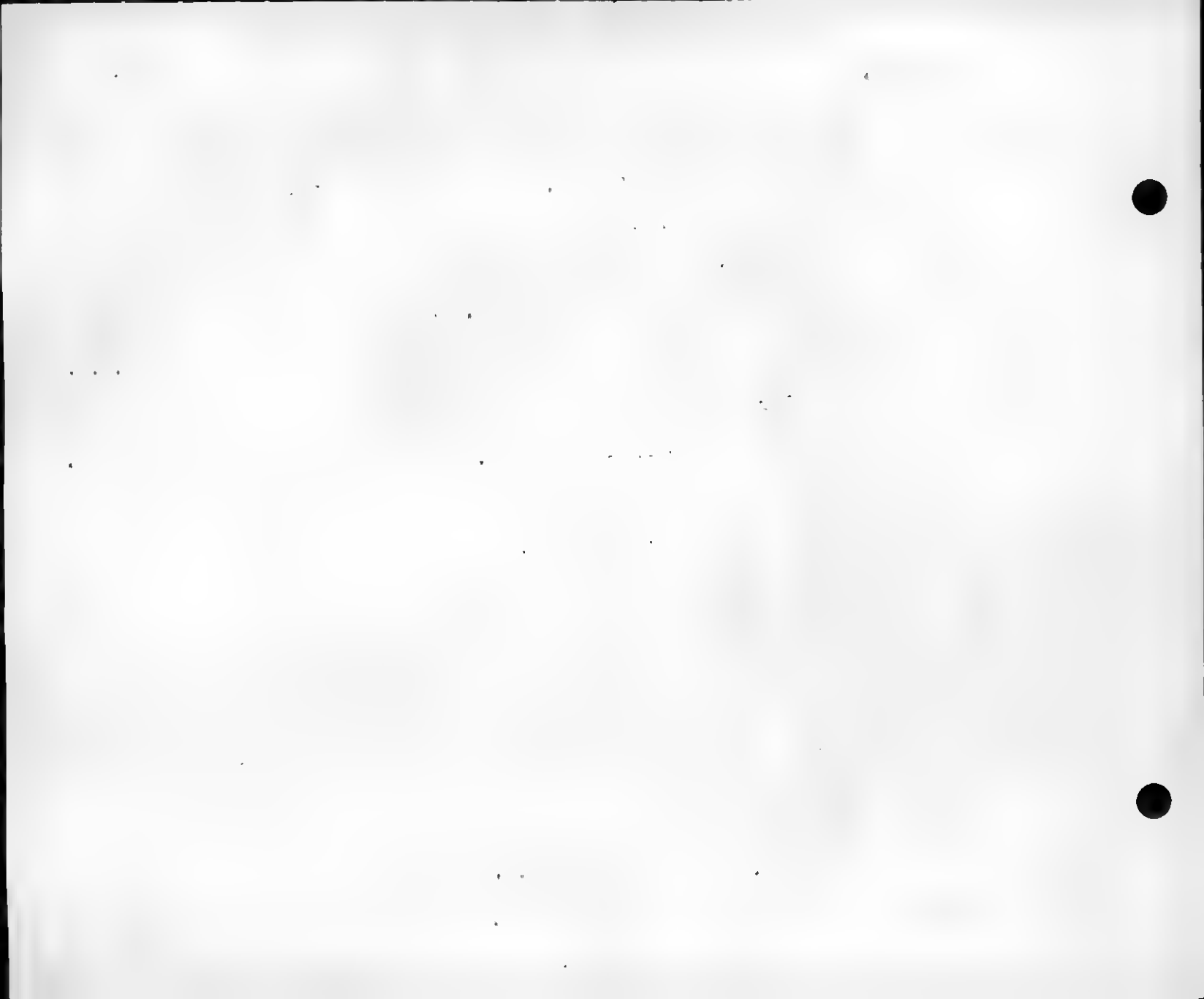
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE MARYLAND b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c LENGTH OF STAY IN 1b 2 Mons.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING HILL PRIVATE SANI				d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MATILDE Middle KESSLER Last COCHRAN				4 DATE OF DEATH Month JULY Day 14 Year 19 66			
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1880		9 AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during part of work, no job, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11 BIRTHPLACE (County & State, or foreign country) Montana		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Kessler				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-48-1677		17. INFORMANT Address MRS. FRANCIS HAYMAN PRINCESS ANNE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular occlusive disease 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis, cerebral DUE TO (c) generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 6 mos 4 yrs 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Aug , 19 63 to July , 19 66 , that (1) (we) last saw the deceased alive on July 14 19 66 , and that death occurred at 12:03 PM from causes and on the date stated above.							
22a. SIGNATURE John T. Bulkeley				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-15-1966	
22c. PHYSICIAN'S NAME (Type) JOHN T. BULKELEY				22d. ADDRESS PINE BLUFF ROAD, SALISBURY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/15/1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR Charles J. ...				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 20 1966	
				25b. REGISTRAR'S SIGNATURE Charles J. ...			

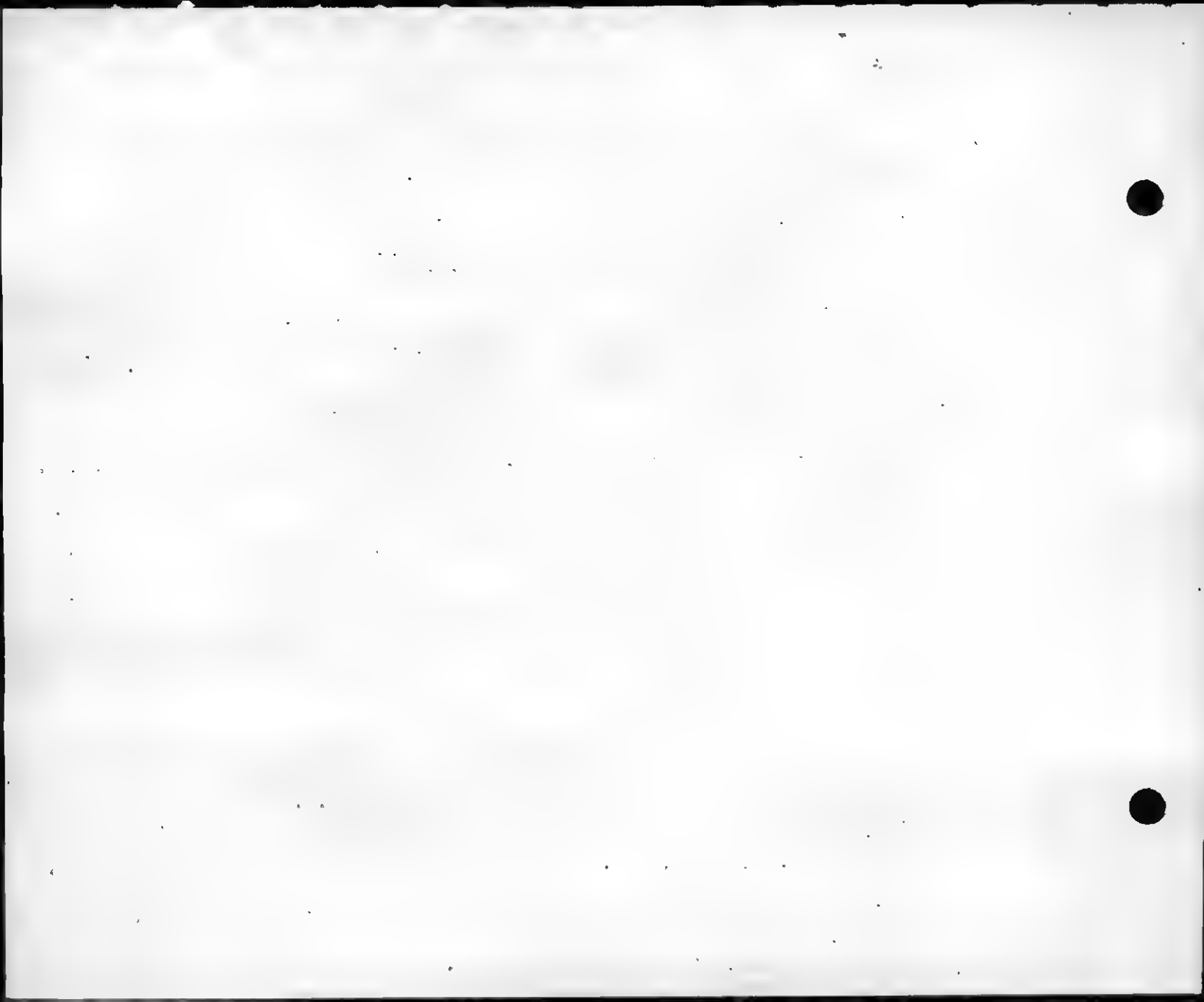


THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 124 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton d. STREET ADDRESS Bay Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hilary Middle Cleveland Last Coleburn		4. DATE OF DEATH Month July Day 16 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Coleburn		14. MOTHER'S MAIDEN NAME Emma Hudson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-6717	
17. INFORMANT E. W. Coleburn, Newtown Square, Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease		Yrs.	
(c) Senility		Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 66 , to 7/16 , 19 66 , that (I) (we) last saw the deceased alive on 7/16 , 19 66 , and that death occurred at 9:30 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 7/18/66	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M.D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-19-1966	
23c. NAME OF CEMETERY Porterville Cemetery		23d. LOCATION (City, town or county) (State) Rural-Stockton, Maryland	
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR JUL 20 1966	
ADDRESS Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

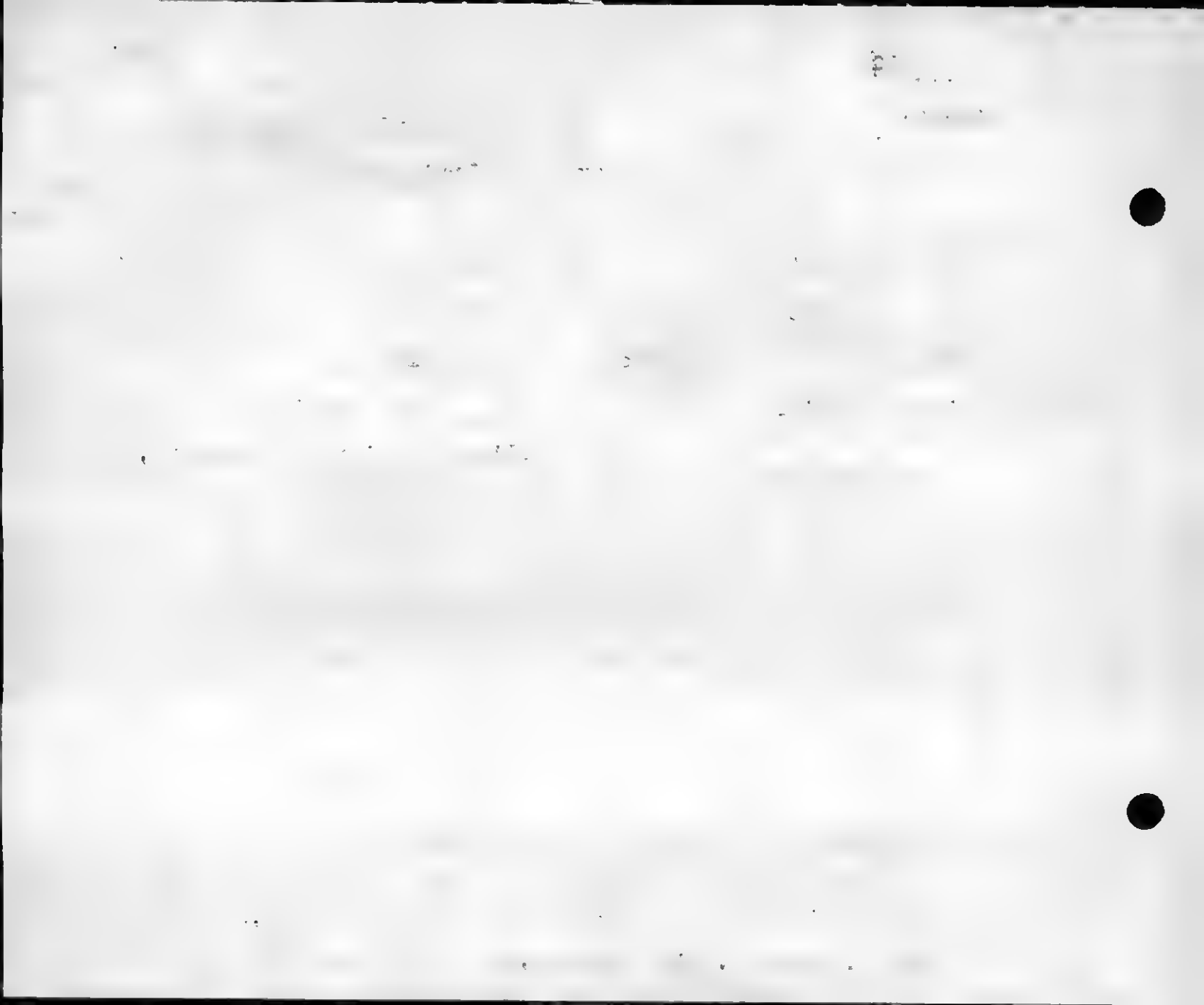


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fruitland			c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fruitland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First Oliver Middle Collier Sr Last Collier Sr					4. DATE OF DEATH Month 7 Day 22 Year 19 66				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/1890		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 22 Hours 19 Mln.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Handy Collier					14. MOTHER'S MAIDEN NAME Ella Dashfield				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Oliver Collier Jr Fruitland, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 260 X DUE TO (b) Hypertensive C-V Disease DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 to July 23 , 19 66 , that (I) (we) last saw the deceased alive on July 23 , 19 66 , and that death occurred at 8 PM , from the causes and on the date stated above.									
22a. SIGNATURE William H. James Jr					22b. DATE SIGNED 7/26/66		22c. PHYSICIAN'S NAME (Type)		
22d. ADDRESS					22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/26/66		23c. NAME OF CEMETERY OR CREMATORY St Paul		23d. LOCATION (City, town or county) (State) Revell, s Maryland		
24. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md					25a. REC'D BY REGISTRAR JUL 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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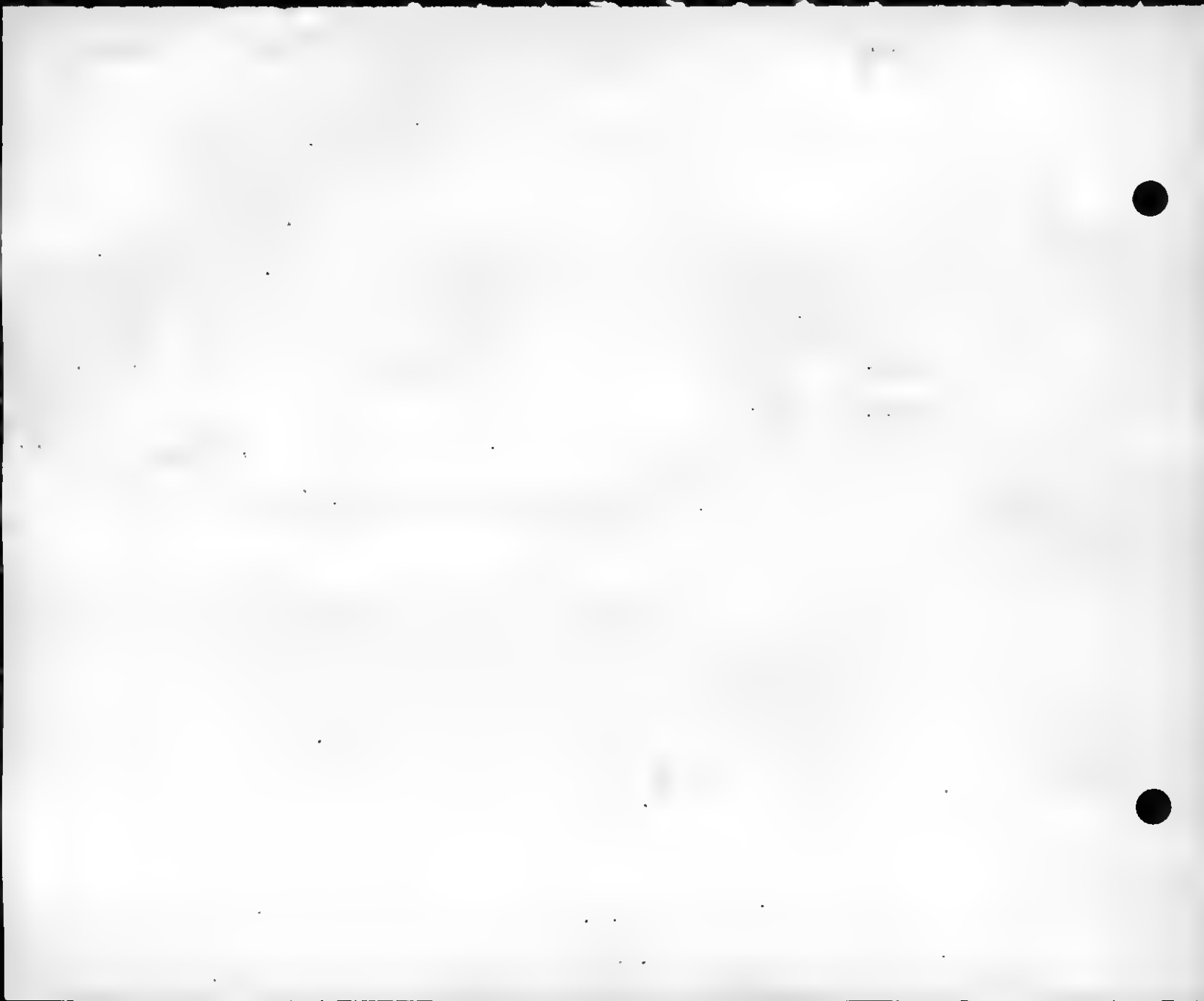
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND,

CERTIFICATE OF DEATH

10604

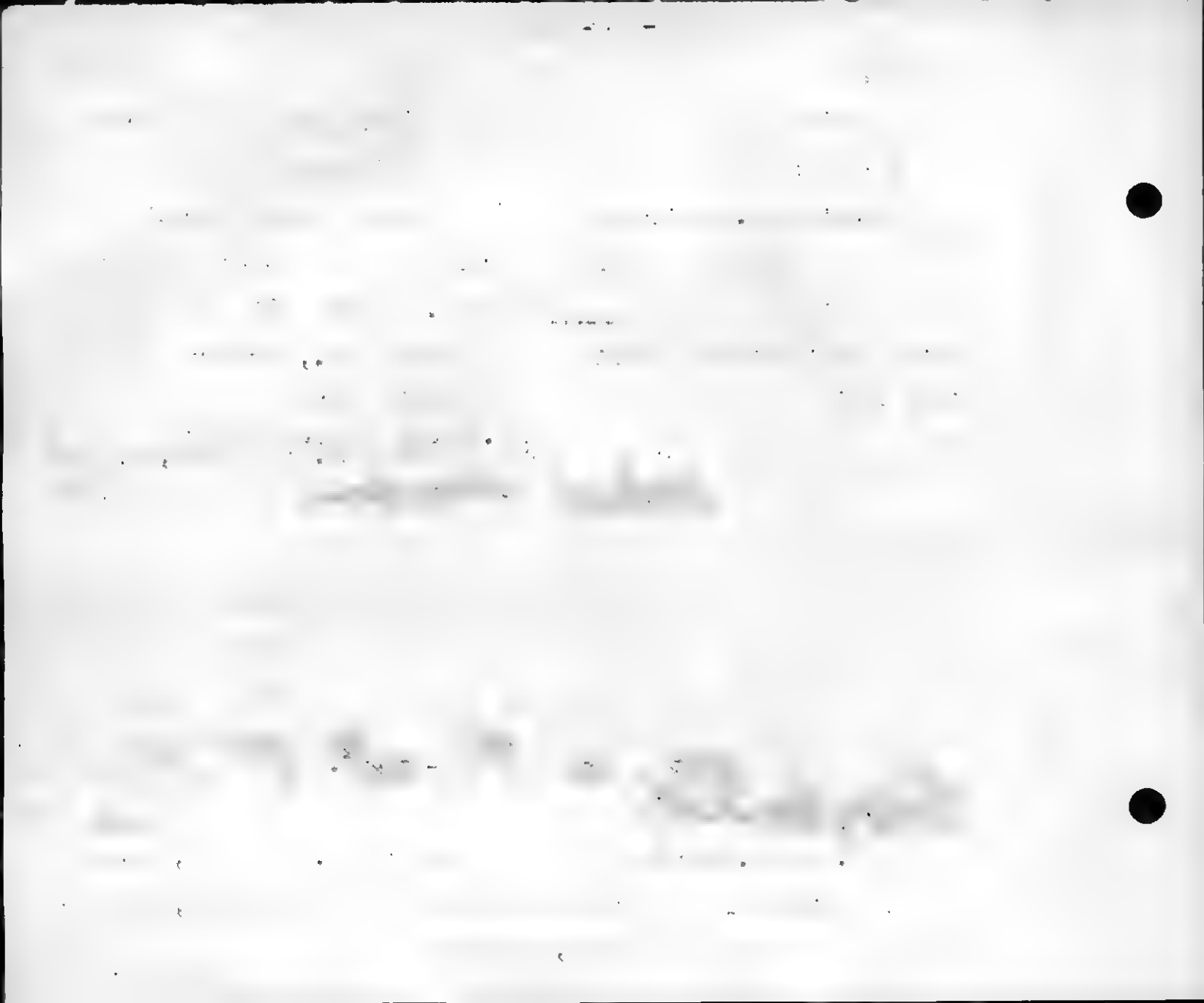
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsular General</u>				d. STREET ADDRESS <u>139 Second St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clifford Cottman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/13/1921</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS. <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			
13. FATHER'S NAME <u>Clifford Cottman</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Polk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Myrtle Cottman</u>			
17. INFORMANT <u>Myrtle Cottman</u>				Address <u>139 Second St. Salis. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma probably of primary</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> , 19 <u>64</u> , to <u>7-28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-28</u> , 19 <u>66</u> , and that death occurred at <u>5:00</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>NEVINS W. TODD JR.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>NEVINS W. TODD JR.</u>				22d. ADDRESS <u>Medical Bldg. - Salisbury</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/27/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Green Arcos Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR <u>Arthur H. Stewart</u>				25a. REC'D BY REGISTRAR <u>Salis Md.</u>			
25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>				DATE <u>AUG 1 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico Co. Nursing Home					d. STREET ADDRESS 208 Saratoga Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last PERCY LAIRD DAVIS					4. DATE OF DEATH Month Day Year July 28 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 5/1900		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Taxi Driver					10b. KIND OF BUSINESS OR INDUSTRY Taxi		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Laird Davis					14. MOTHER'S MAIDEN NAME Georgia Horner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk					16. SOCIAL SECURITY NO.					
17. INFORMANT Mrs. Harold Taylor (Sister)					Address 208 Saratoga St., Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Long										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from 7/1 to 7/28 , 19 66 , that (I) (we) last saw the deceased alive on 7/27 , 19 66 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Dr. Earl M. Beardsley										
22b. DATE SIGNED July 29/1966										
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley										
22d. ADDRESS Maryland Ave. Salisbury, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										
23b. DATE THEREOF XXXX 8/1/66										
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park										
23d. LOCATION (City, town or county) (State) Salisbury, Maryland										
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY										
ADDRESS SALISBURY, MARYLAND										
25a. REC'D BY REGISTRAR AUG 3 1966										
25b. REGISTRAR'S SIGNATURE Charles Judge										



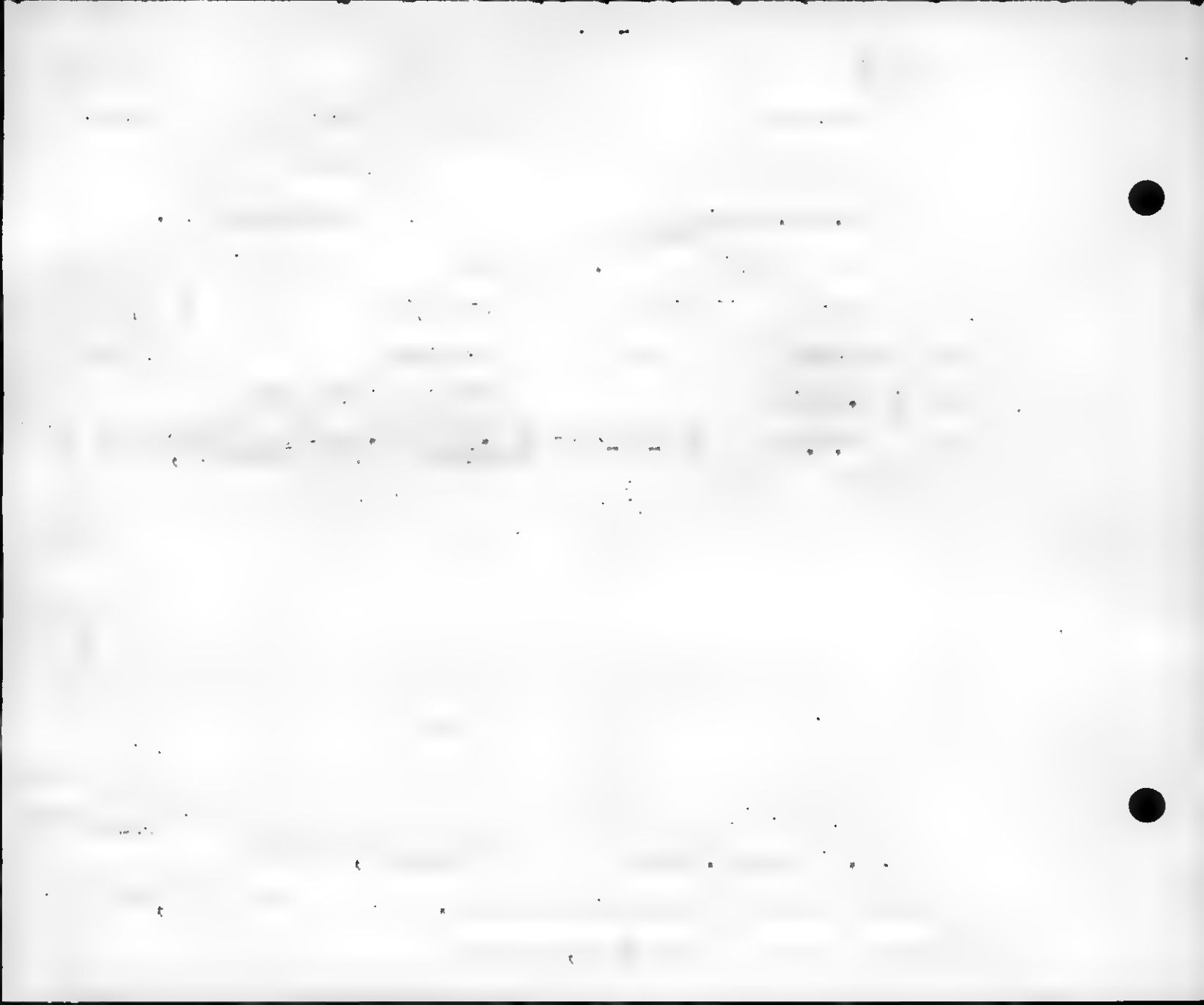
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

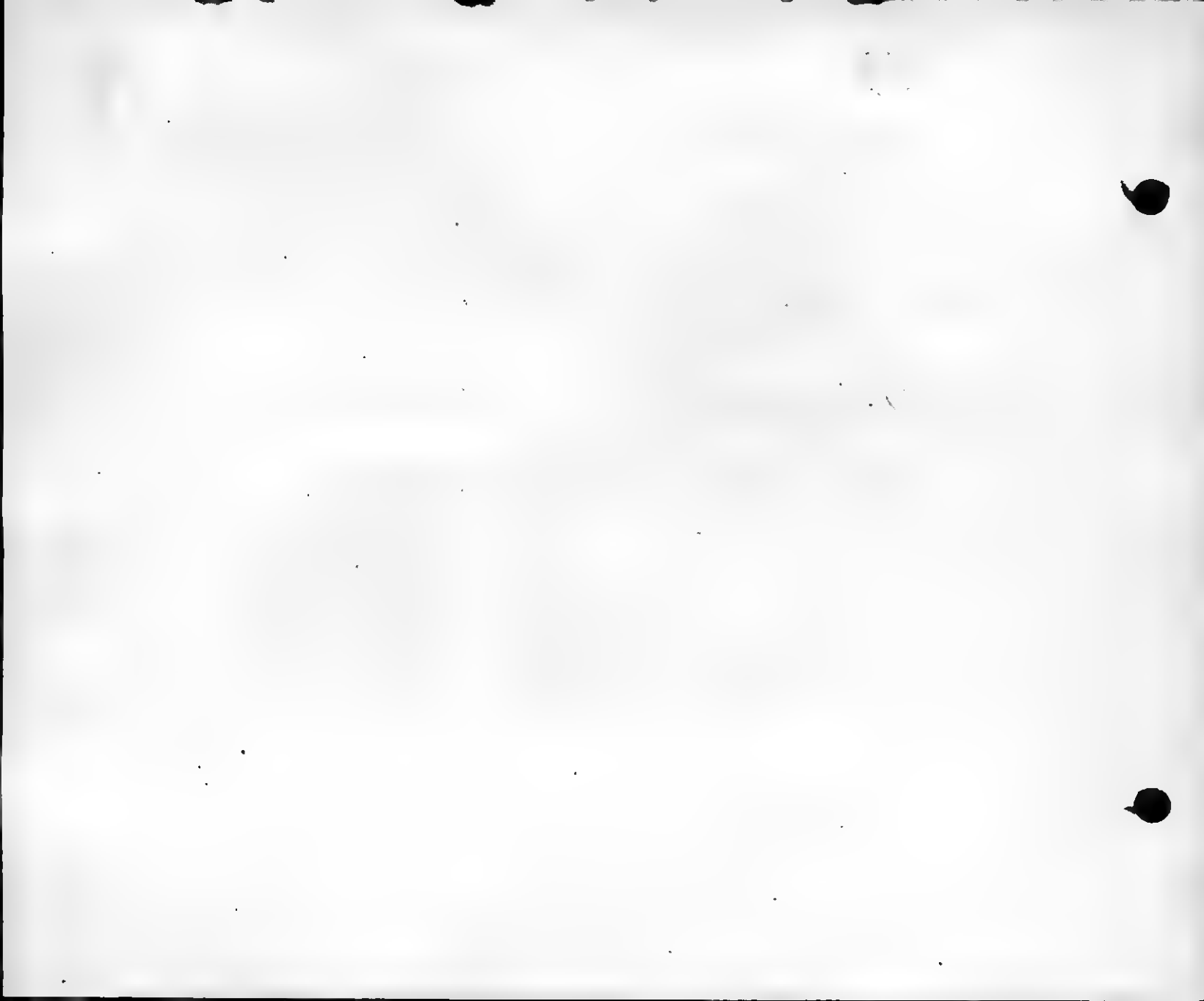
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10672					10666				
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen. Gen. Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 223 Monticello Ave.				
3. NAME OF DECEASED (Type or print) THOMAS H. DAVIS			First Houston Middle Middle Last DAVIS		4. DATE OF DEATH JULY 11 1966 Month July Day 11 Year 1966			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4/1912 yrs. 54 Months 0 Days 7 Hours Min. 		9. AGE (In years last birthday) 54 yrs. 0 Months 7 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman			10b. KIND OF BUSINESS OR INDUSTRY Car			11. BIRTHPLACE (County & State, or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert P. Davis					14. MOTHER'S MAIDEN NAME Lillian Terebaugh				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give way or dates of service) W.B.#2			16. SOCIAL SECURITY NO. 443-09-5981		17. INFORMANT Mrs. Pearl W. Davis (Wife) Address 223 (Blvd Apts) Monticello Ave Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Anginal Factors Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 1 day 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A						
20c. TIME OF INJURY Month, Day, Year Hour a.m. N/A p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) N/A (State) N/A		
21. I certify that (I) (this hospital) attended the deceased from July 6/1966 to 7/11 , 19 66 that (I) (we) last saw the deceased alive on 19 , and that death occurred at 11 M. from the causes and on the date stated above.									
22a. SIGNATURE W. B. Smith					22b. DATE SIGNED July 13/1966		22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF July 15/1966		23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens		23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR JUL 15 1966		25b. REGISTRAR'S SIGNATURE see reg journal		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10667									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin Maryland</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>313 Branch St.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Elwood</u> First Middle Last					4. DATE OF DEATH <u>July 23</u> 19 <u>66</u> Month Day Year				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>Negro</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>1-14-1903</u> 63 yrs.				
9. AGE (In years last birthday)					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Worcester</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>ISSAIAH Derrickson</u>					14. MOTHER'S MAIDEN NAME <u>Lillian Smack</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>171-10-5393</u>				
17. INFORMANT					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>									
331X DUE TO (b) <u>Hypertensive Cerebral Vascular Disease</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Disease</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>7/17/1966</u> to <u>7/23/1966</u> that (I) (we) last saw the deceased alive on <u>7/22/1966</u> and that death occurred at <u>4:00</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)									
22d. ADDRESS									
22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
23b. DATE THEREOF									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR <u>Loretta B. Jolley - Jersey Rd Rt #2 Salis.</u>									
25a. REC'D BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									
DATE <u>JUL 26 1966</u>									



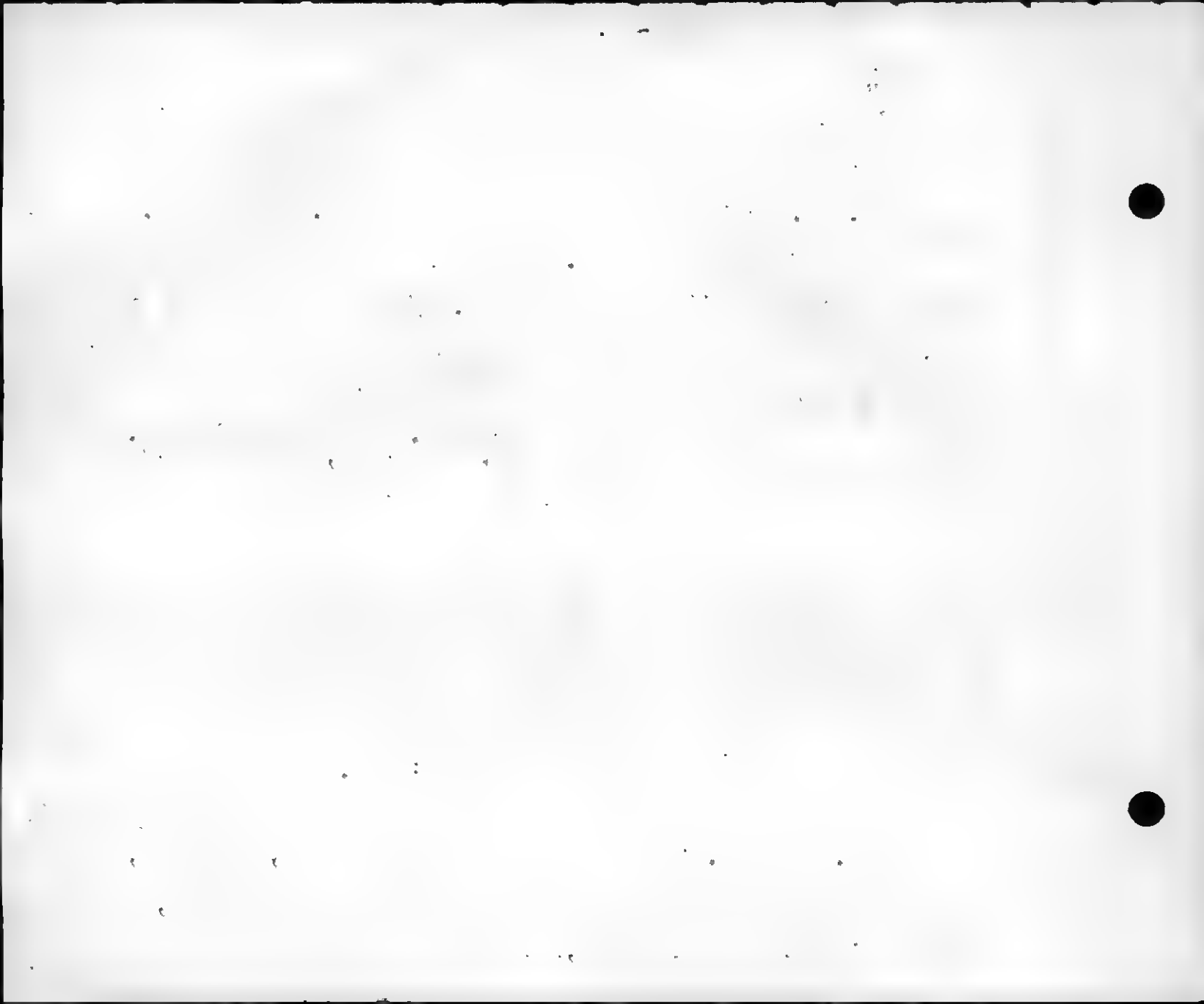
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen.Gen.Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 315 E.College Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MADELINE Middle C. Last DERRY		4. DATE OF DEATH Month JULY Day 17 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug.28/1919
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR: Months 10 Days 19 Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Louis Chicoine		14. MOTHER'S MAIDEN NAME Bertha Hinkley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Norman V.Derry (Husband)		Address 315 E.College Ave., Salisbury, Maryland 21801	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) CORONARY Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from July 13, 1966 to July 17, 1966 , that (I) (we) last saw the deceased alive on July 16, 1966 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas C Hill Jr.		22b. DATE SIGNED July 19/1966	
22c. PHYSICIAN'S NAME (Type) Dr.Thomas C.Hill		22d. ADDRESS Pine Bluff Road, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 20/1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR JUL 22 1966	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

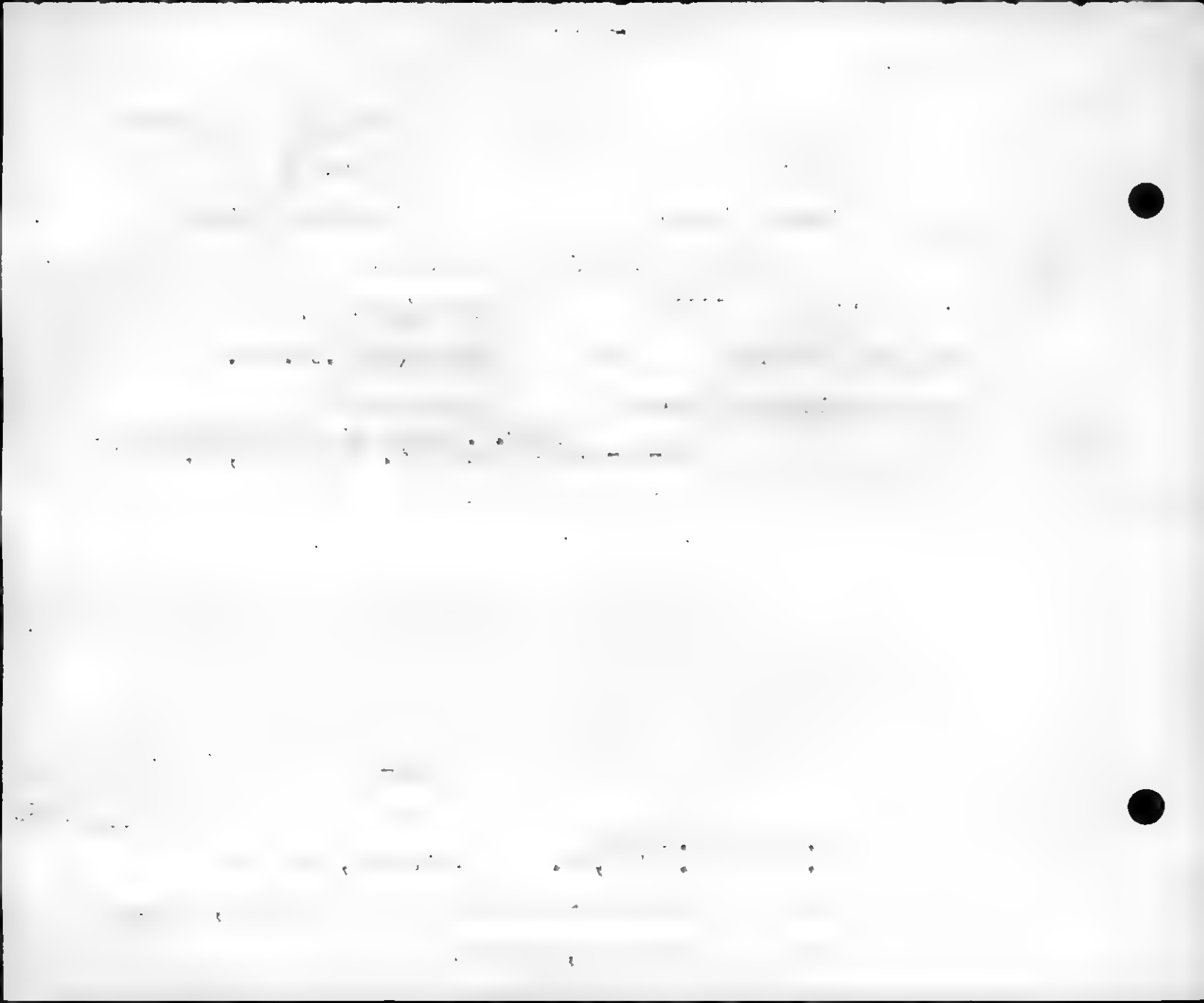


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VR A15 (4)
20M 1/65

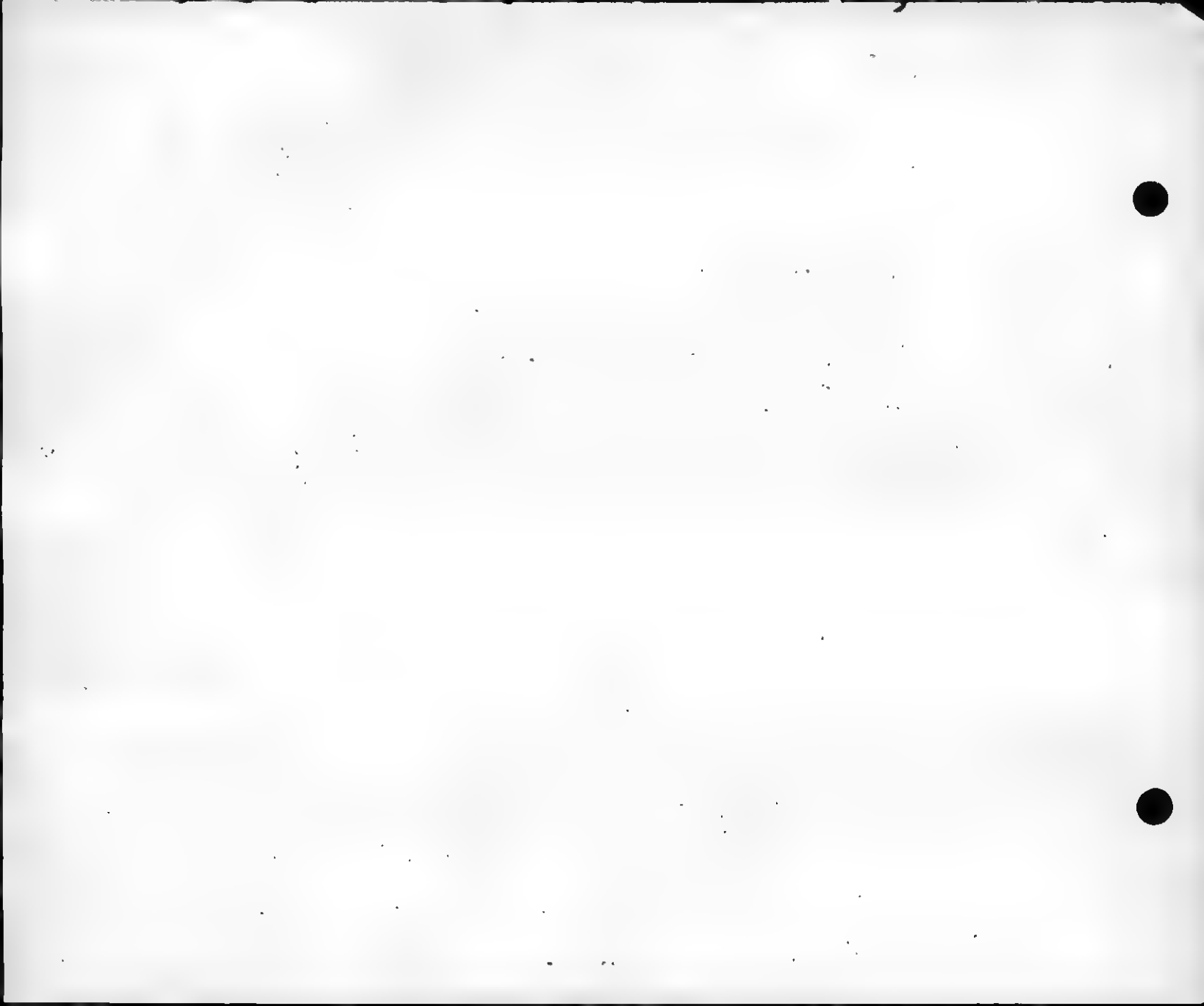
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN ID		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 826 Cooper Street						d. STREET ADDRESS 826 Cooper Street					
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last DISHAROON						4. DATE OF DEATH Month JULY Day 13 Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13/1890		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Melson (Wico. Co.) Md.				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Washington Parsons						14. MOTHER'S MAIDEN NAME Zudar Sears					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-22-9421A		17. INFORMANT Mr. W. Arthur Disharoon (Husband) Address 826 Cooper St. Salisbury, Md. 21801					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intractable cardiac failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None										INTERVAL BETWEEN ONSET AND DEATH 14 MON YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1-12 , 19 61 , to 7-13 , 19 66 , that (I) (we) last saw the deceased alive on 7-8 , 19 66 , and that death occurred at 7 A M, from the causes and on the date stated above.											
22a. SIGNATURE Dr. Robert T. Adkins						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 13/1966		22c. PHYSICIAN'S NAME (Type) Dr. Hubert R. White, Jr.	
22d. ADDRESS Fruitland, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 19/1966		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery				23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY						ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUL 15 1966		25b. REGISTRAR'S SIGNATURE <i>Charles J. J.</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
10676													
10640													
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution/Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Sussex</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millsboro</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						d. STREET ADDRESS <u>R. F. D. 2</u>							
3. NAME OF DECEASED (Type or print) <u>WILLIAM B. DOREY</u>						4. DATE OF DEATH Month <u>JULY</u> Day <u>25</u> Year <u>1966</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building Contractor</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>James E. Dorey</u>						14. MOTHER'S MAIDEN NAME <u>Maggie J. Rust</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>222-09-0370</u>		17. INFORMANT <u>Howard Dorey</u>		Address <u>Millsboro, Del.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>421</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD.</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Massive ST Hemorrhage & anemia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7-21</u> , 19 <u>66</u> , to <u>7-25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/25/66</u> 19 <u>66</u> , and that death occurred at <u>4:48</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-25-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u>						22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Millsboro Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Millsboro, Del.</u>							
24. FUNERAL DIRECTOR <u>Donald James</u>						ADDRESS <u>Millsboro, Del.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>AUG 1 1966</u>													



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10677

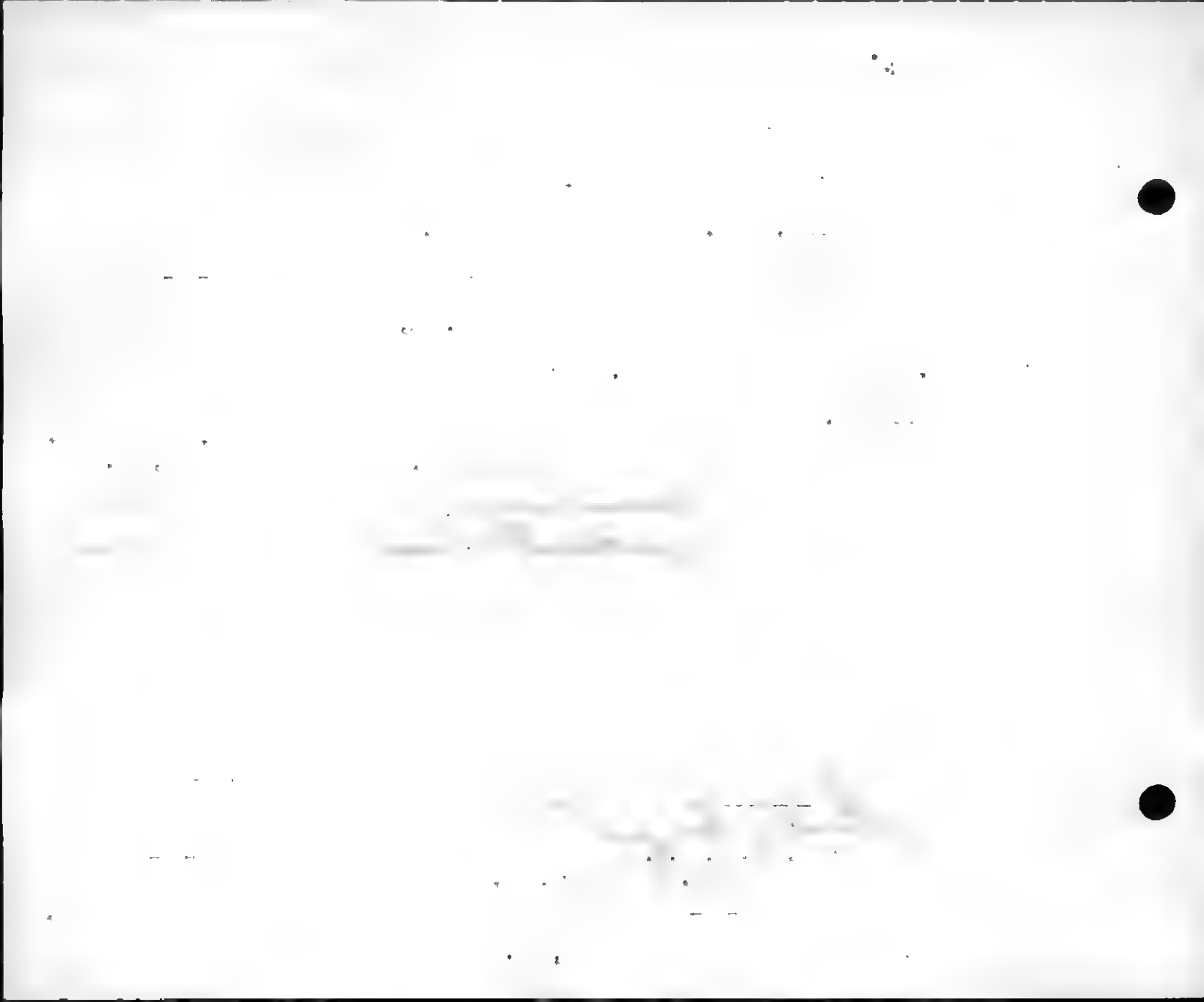
10671

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Hill R. Sani.				d. STREET ADDRESS N. Park Gardens		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Claude Collier Dorman				4 DATE OF DEATH Month Day Year 7-27-66 19			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1883	9. AGE (In years last birthday) 82	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William E. Dorman				14. MOTHER'S MAIDEN NAME Lula Collier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No X		16. SOCIAL SECURITY NO.		17. INFORMANT Richard D. Leviness		321 N. Division St. Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5410 DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Duodenal Ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. 19		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden ave. Salisbury, Md.		22. DATE SIGNED 7-29-66		23a. BURIAL, CREMATION, REMOVAL Burial			
23b. DATE THEREOF 7-30-66		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR Hill Funeral Home		ADDRESS Salisbury, Md.		25a. RECD BY REGISTRAR DATE AUG 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



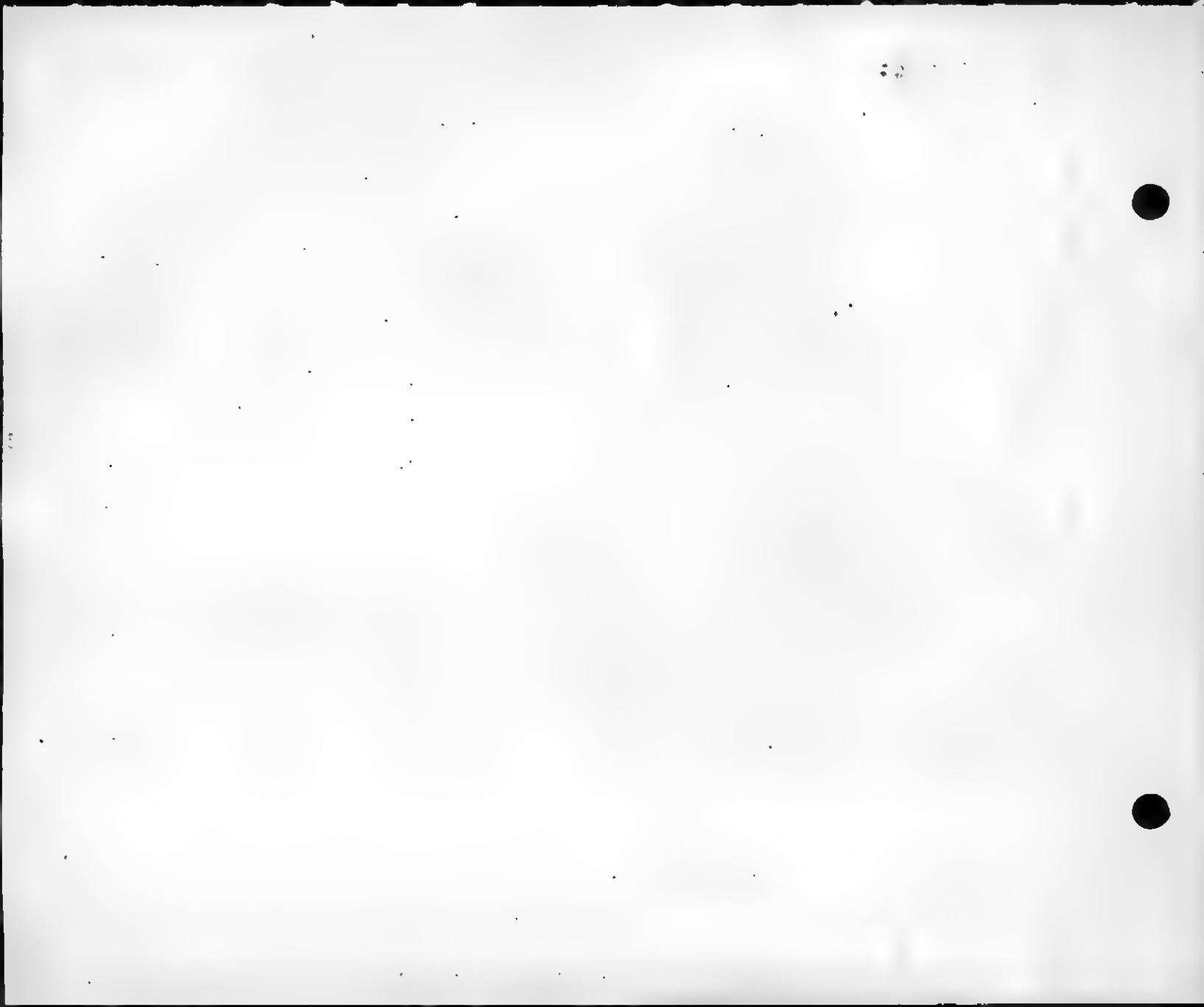
FOR STATE-
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Penin Sula General Hosp</i>		e. STREET ADDRESS <i>3033 Seamon Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Dorsey</i> Last		4. DATE OF DEATH Month <i>7</i> Day <i>9</i> Year <i>1966</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 1 - 1917</i>
9. AGE (in years last birthday) <i>49</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Grand Rapid Mich</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Arnon Dorsey</i>		14. MOTHER'S MARDEN NAME <i>Pearl P</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>War II</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Jackie Dorsey</i> Address <i>3033 Seamon Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary + thrombosis</i> <i>+201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>7-9</i> a.m. <i>1966</i> p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <i>Ocean City Worcester Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Philip A. Insley</i>		22. DATE SIGNED <i>7-9-66</i>	
EXAMINER'S NAME (Type) <i>Ph. Lp A. Insley</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>7-14-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Balto National Em</i>	23d. LOCATION (City, town or county) (State) <i>Balto Md</i>
24. FUNERAL DIRECTOR <i>Rayner Sanders</i> ADDRESS <i>217 E. Preston St</i>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>W. J. Sanders, Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

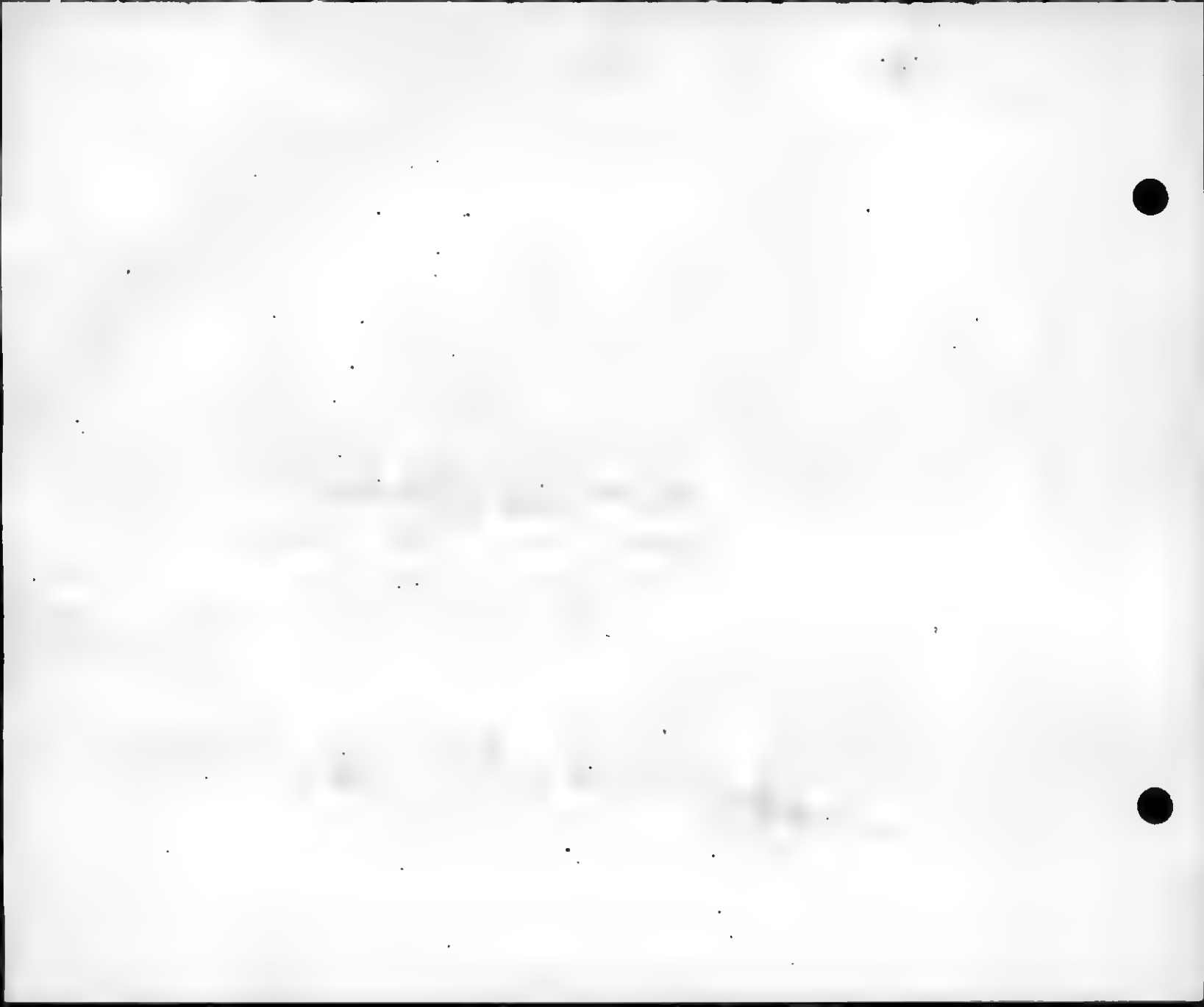
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.			b. COUNTY Worcester		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stockton			d. STREET ADDRESS Box 107		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ALONZA		First Middle Last DRUMMOND		4. DATE OF DEATH JULY 6 1966					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 22, 1910		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Knox		14. MOTHER'S MAIDEN NAME Julia Drummond							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 231-01-6743		17. INFORMANT Clara Drummond		Address Stockton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA COLI X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) RECTAL CARCINOMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/8, 1966, to 7/6, 1966, that (I) (we) last saw the deceased alive on 7/6, 1966, and that death occurred at 10:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE D.M. Barish		M.D.		ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-10-66		23c. NAME OF CEMETERY OR CREMATORY Home Beneficial Cem.		23d. LOCATION (City, town or county) (State) Stockton, Md.			
24. FUNERAL DIRECTOR Samuel Kennedy		ADDRESS New Church, Va.		25a. REC'D BY REGISTRAR DATE JUL 11 1966		25b. REGISTRAR'S SIGNATURE James J. Juge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		d. STREET ADDRESS <u>205 PHILA. AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Joe S. ELLIOTT</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>SEPT</u> Day <u>29</u> Year <u>1897</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COMMERCIAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME <u>JOHN ELLIOTT</u>		14. MOTHER'S MAIDEN NAME <u>ANN ZULLEN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-6771</u>		17. INFORMANT <u>MR. J.S. ELLIOTT</u>		Address <u>R. OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Hyper-tensive Heart Disease and</u> DUE TO (c) <u>Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>45 mins.</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7/18/66</u> to <u>7/24/66</u> , that (I) (we) last saw the deceased alive on <u>7/24/66</u> , and that death occurred at <u>2:05</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Oswald J. Burton</u>		22d. ADDRESS <u>Medical Center Salisbury Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>Berlin MD</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u>		ADDRESS <u>Berlin Md</u>		DATE <u>JUL 27 1966</u>							



1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

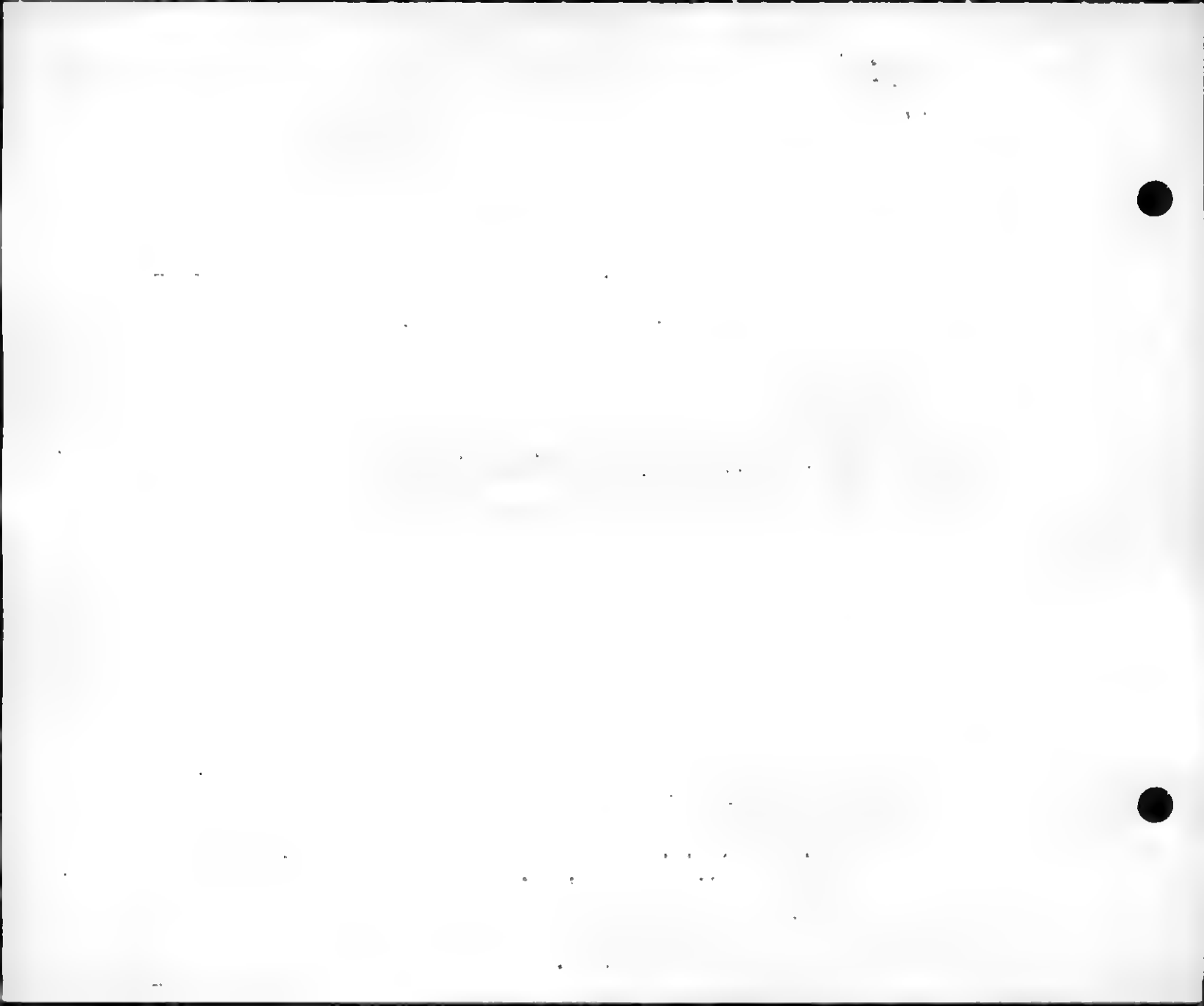
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in all events within 72 hours after death.

10681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10675

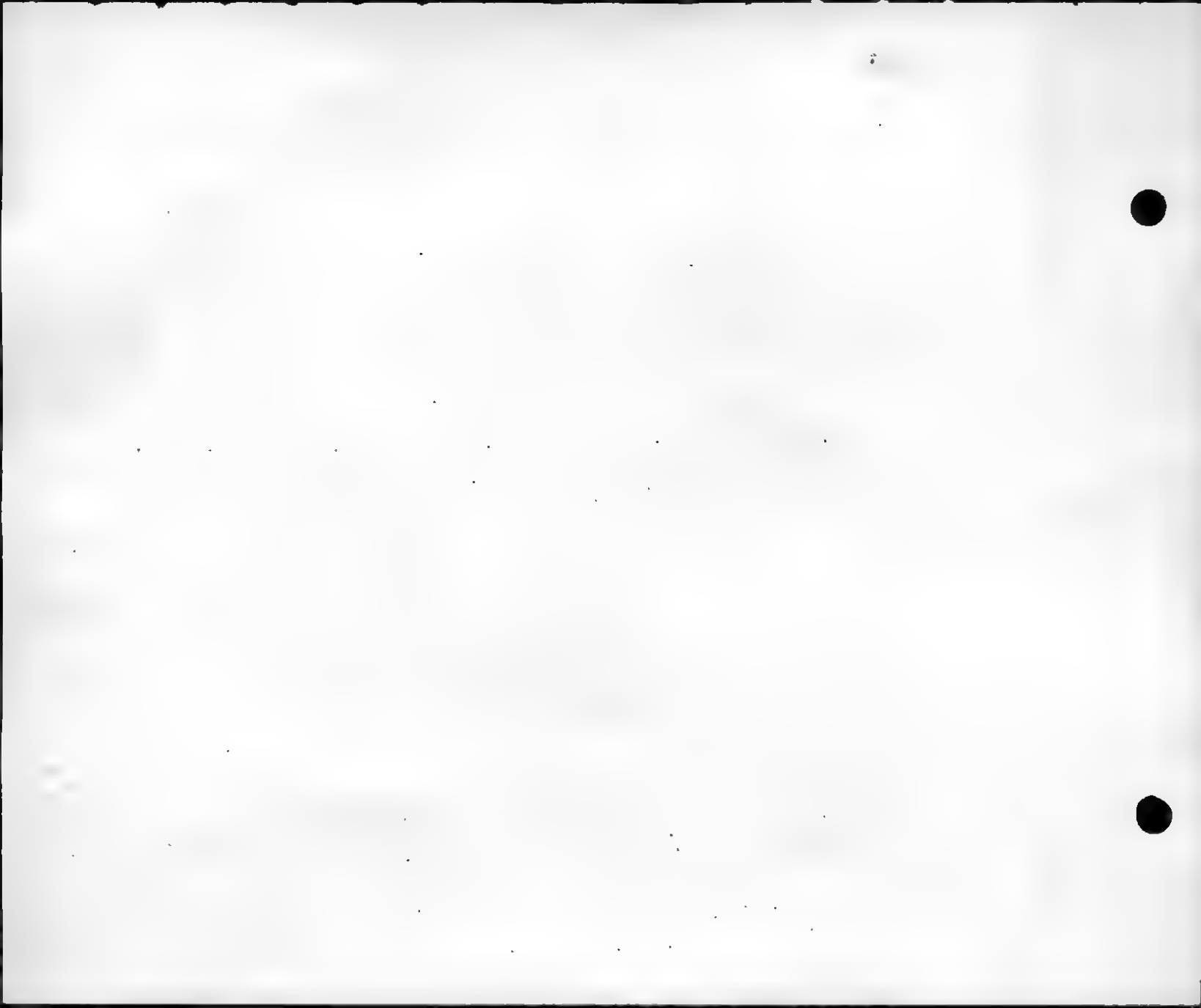
1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) DQA Peninsula General Hospital		d STREET ADDRESS e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last CHARLES A. ENNIS		4 DATE OF DEATH Month Day Year 7-17-66 19	
5 SEX Male	6 COLOR OR RACE AA	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 4, 1898
9 AGE (In years last birthday) yrs 68		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give year or dates of service Yes World War II		16 SOCIAL SECURITY NO 217-30-7878	
17 INFORMANT Winifred Hall, Tyaskin, Md.		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4701 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRASTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED July 19, 1966	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7/31	
23c NAME OF CEMETERY OR CREMATORY Tyaskin Cem.		23d LOCATION (City or Town) (County) (State) Tyaskin, Md.	
24 FUNERAL DIRECTOR Messick Funeral Home, Bivalve, Md.		25a REC'D BY REG STRAR JUL 21 1966	
25b REGISTRAR'S SIGNATURE James Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>												
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u> </u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dagsboro</u> d. STREET ADDRESS <u>Rural (Vine Ck. Rd.)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>WILLIAM</u> Middle <u>ENNIS</u> Last			4. DATE OF DEATH <u>July</u> Month <u>10</u> Day <u>19</u> Year <u>66</u>		5. SEX <u>MALE</u>			6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>March 4, 1910</u>			9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William G. Ennis</u>					14. MOTHER'S MAIDEN NAME <u>Mrs. Blanche Ennis</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u>212-12-3966</u>		17. INFORMANT <u>Rosalie Ennis, Dagsboro, Del.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7-6</u>, 19<u>66</u>, to <u>7-10</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>7-10</u>, 19<u>66</u>, and that death occurred at <u>3:45</u> A.M., from the causes and on the date stated above.												
22a. SIGNATURE <u>James L. Clifford</u>					22b. DATE SIGNED <u>7-10-66</u>		22c. PHYSICIAN'S NAME (Type) <u>James L. Clifford</u>					
22d. ADDRESS <u>Medical Center Salisbury, Md.</u>					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bishopville, (Oddfellows)</u>			23d. LOCATION (City, town or county) (State) <u>Bishopville, Md.</u>				
24. FUNERAL DIRECTOR <u>Charles Judge</u>					25a. REC'D BY REGISTRAR <u>JUL 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

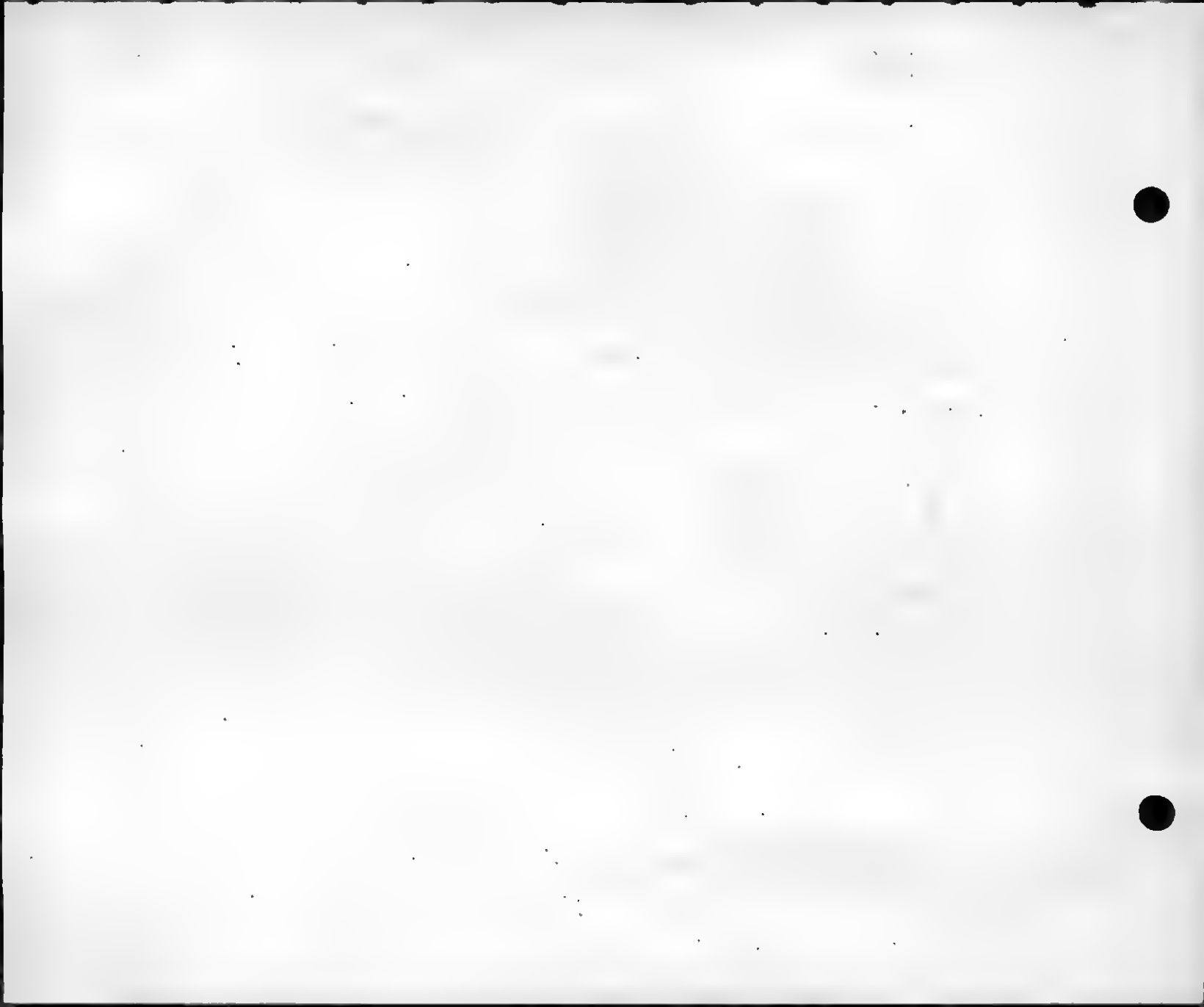


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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
10683 Item 2 File 7-12-66 10677 Item 7 File 7-12-66													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WICOMICO</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALESBURY</u>						c. LENGTH OF STAY IN 1b							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>AN INSULA GENERAL HOSPITAL</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> 22-1							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						d. STREET ADDRESS <u>RT # 3</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT OSCAR FIGGS</u>						4. DATE OF DEATH Month Day Year <u>JULY 9 19 66</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 2, 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>				11. BIRTHPLACE (County & State, or foreign country) <u>DELMAR - MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>BENJAMIN FIGGS</u>						14. MOTHER'S MAIDEN NAME <u>MARY JANE MADDOX</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO. <u>NONE</u>							
17. INFORMANT <u>ALBERT FIGGS</u>						Address <u>DELMAR - MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pericious Anemia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/1966</u> to <u>7/9/1966</u> , that (I) (we) last saw the deceased alive on <u>7/9/1966</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED <u>[Signature]</u>							
22c. PHYSICIAN'S NAME (Type) <u>OSWALD S. BURTON</u>						22d. ADDRESS <u>MEDICAL CENTER - SALESBURY, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>7-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MELSON</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR - MD</u>			
24. FUNERAL DIRECTOR <u>Charles W. Howell - Delmar, Del.</u>						25a. REC'D BY REGISTRAR <u>[Signature]</u>							
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						DATE <u>JUL 12 1966</u>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files.

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1

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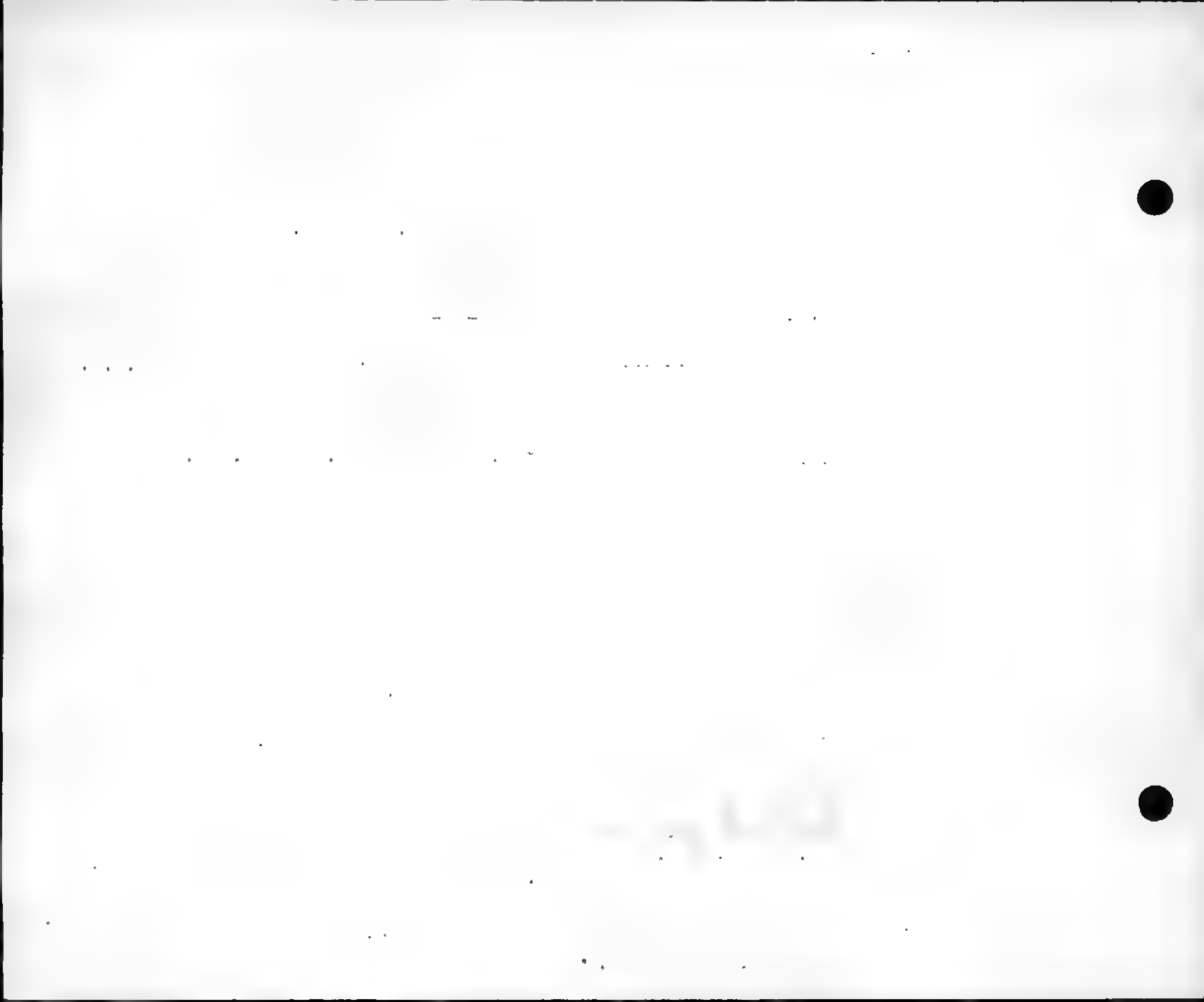
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10678

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b Delmar			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS W. East St.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LLOYD Last FURBUSH				4. DATE OF DEATH Month July Day 25 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-1952	
9. AGE (In years last birthday) 13 yrs		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min 13		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lloyd Ira Furbush				14. MOTHER'S MAIDEN NAME Betty Tucker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Betty Powell, Delmar, Md. (mother)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning 1298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1298 DUE TO (c) 1298						INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell into irrigation pond.			
20c. TIME OF INJURY Month, Day, Year 1:15 p.m. 7-25-66				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Irrigation pond	
20f. (City or town) Delmar, Maryland				20g. (County) Wicomico			
20h. (State) Maryland				20i. (City or town) Delmar, Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				22. DATE SIGNED July 26, 1966			
EXAMINER'S NAME (Type) 409 Camden Ave, Salisbury, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)			
23a. BURIAL (Specify) Burial		23b. DATE THEREOF 7-28-66		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Smyrna Del.	
24. FUNERAL DIRECTOR Marvel Funeral Home, Delmar, Del.				25a. REC'D BY REGISTRAR DATE JUL 28 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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1 (M)

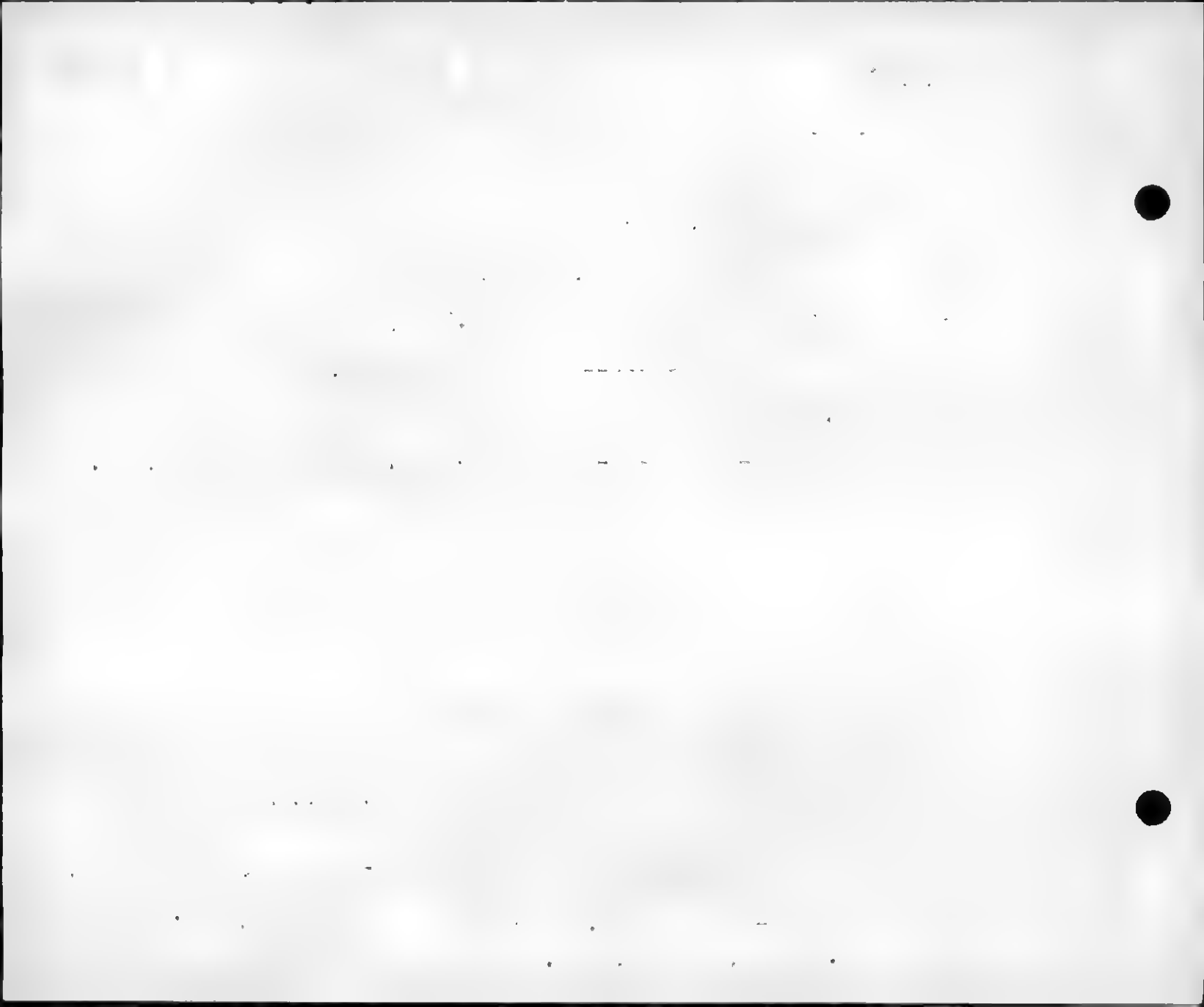
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10685

CERTIFICATE OF DEATH

19679

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b 3205 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e STREET ADDRESS 304 East Street	
3. NAME OF DECEASED (Type or print) First Ruth Middle A. Last Gravenor		4. DATE OF DEATH Month July Day 31 Year 19 66	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 12, 1915
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State or foreign country) Belleville, Ill		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Walter F. Beyer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 328-03-6549	
17. INFORMANT Howard W. Gravenor, Delmar, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 1721 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma, left submandibular gland, DUE TO (c) metastases to cervical glands		INTERVAL BETWEEN ONSET AND DEATH days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy, grand mal - years		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 10/21 , 19 57 , to 7/31 , 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/31 , 19 66 , and that death occurred at 7:28 A.M. from causes and on the date stated above.			
22a. SIGNATURE C. H. Winnacott		22b. DATE SIGNED 7/31/66	
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22d. ADDRESS Deer's Head Hospital, Salisbury, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-2-66	23c. NAME OF CEMETERY OR CREMATORY St. Stephens	23d. LOCATION (City or Town) (County) (State) Delmar, Del.
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.		25a. REC'D BY REGISTRAR AUG 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

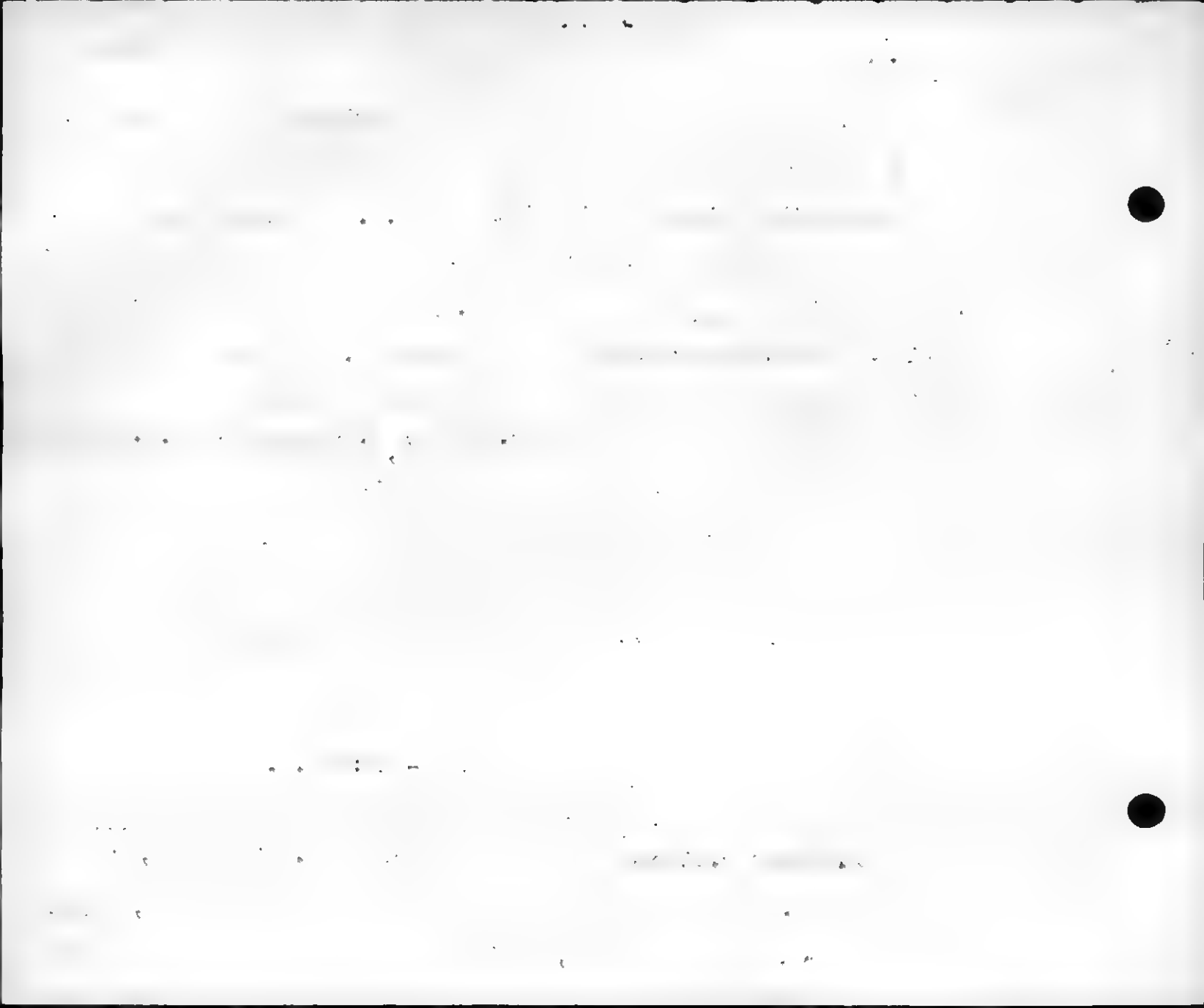


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springhill Private Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS R.D.# 3 Delmar Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SMILEY BENJAMIN HADDOCK First Middle Last 5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 3/1881 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months 08 Days 26 IF UNDER 24 HRS. Hours Min. 		4. DATE OF DEATH July 29 1966 Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telephone Employee 10b. KIND OF BUSINESS OR INDUSTRY Employee 11. BIRTHPLACE (County & State, or foreign country) Sussex Co. Delaware 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nevin Haddock 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Charles F. Haddock (Son) Address R.D. #3 Box #45 Laurel, Delaware (Ph 875 3984)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dilatant pneumonia DUE TO (b) Post-operative status - Myocardial DUE TO (c) 14 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis - Vasculitis - Nephritis 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall from bed breaking hip 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from App - 10:45 P.M. , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. 22a. SIGNATURE Dr. Thomas P. Bigbee M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED July 30/1966 22c. PHYSICIAN'S NAME (Type) Dr. Thomas P. Bigbee 22d. ADDRESS Maryland Ave. Salisbury, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Aug. 1/1966 23c. NAME OF CEMETERY OR CREMATORY Line Church Cemetery 23d. LOCATION (City, town or county) (State) Wicomico County, Maryland 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND 25a. REC'D BY REGISTRAR DATE AUG 3 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HEBRON, Maryland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CHARLES CLIFTON HARRIS</u> First <u>Charles</u> Middle <u>Clifton</u> Last <u>Harris</u> 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-28-08</u> 9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR <u>17</u> Months <u>17</u> Days <u>1966</u>						4. DATE OF DEATH <u>JULY 17 1966</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Frank Harris</u> 14. MOTHER'S MAIDEN NAME <u>Betty Wish</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>231-09-3555</u> 17. INFORMANT <u>Georgie Harris</u> Address <u>Hebron, Md</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>Ca of Colon</u> (c) <u>metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <u>7/16/66</u> , 19 <u>66</u> , to <u>7/17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> , 19 <u>66</u> , and that death occurred at <u>2:15</u> M., from the causes and on the date stated above. 22a. SIGNATURE <u>Joseph C. Fitzgerald</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/17/66</u> 22c. PHYSICIAN'S NAME (Type) <u>JOSEPH C. FITZGERALD</u> 22d. ADDRESS <u>MEDICAL CENTER - SALISBURY, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-23-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>John Westley</u> 23d. LOCATION (City, town or county) (State) <u>Martinsburg, Md</u> 24. FUNERAL DIRECTOR <u>Loretta P. Jolley</u> ADDRESS <u>Jersey Rd. Salis.</u> 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> DATE <u>JUL 22 1966</u>											

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10688

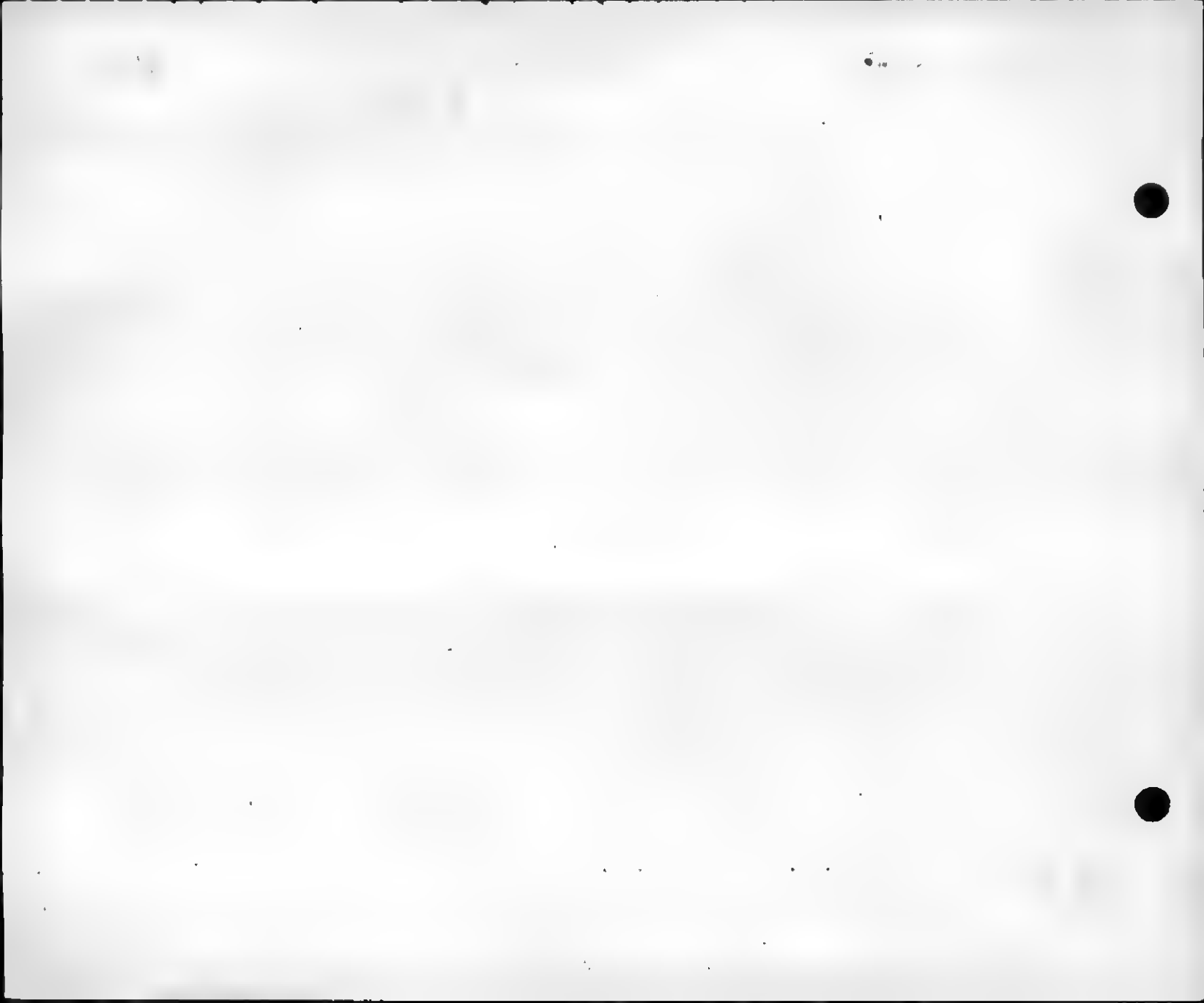
CERTIFICATE OF DEATH

12021

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b 1979 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Box 481	
3. NAME OF DECEASED (Type or print) First Sarah Middle Harris Last Harris		4. DATE OF DEATH Month July Day 30 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1916
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (County & State, or foreign country) Shadyside VA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BENJAMIN AMES		14. MOTHER'S MAIDEN NAME MARY MILES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. John S. Harris	
17. INFORMANT John S. Harris		Address Crisfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 194X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of the thyroid DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paraplegia due to metastatic carcinoma, T 9			INTERVAL BETWEEN ONSET AND DEATH Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/27 , 19 61 , to 7/30 , 19 66 , that (I) (we) last saw the deceased alive on 7/30 , 19 66 , and that death occurred at 10:30 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE Andrew C Mitchell		22b. DATE SIGNED 8/1/66	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL	23b. DATE OF REMOVAL 8/4/66	23c. NAME OF CEMETERY OR CREMATORY Princess Anne	23d. LOCATION (City or Town) (County) (State) Princess Anne Md
24. FUNERAL DIRECTOR Anthony E. Ward		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 9 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



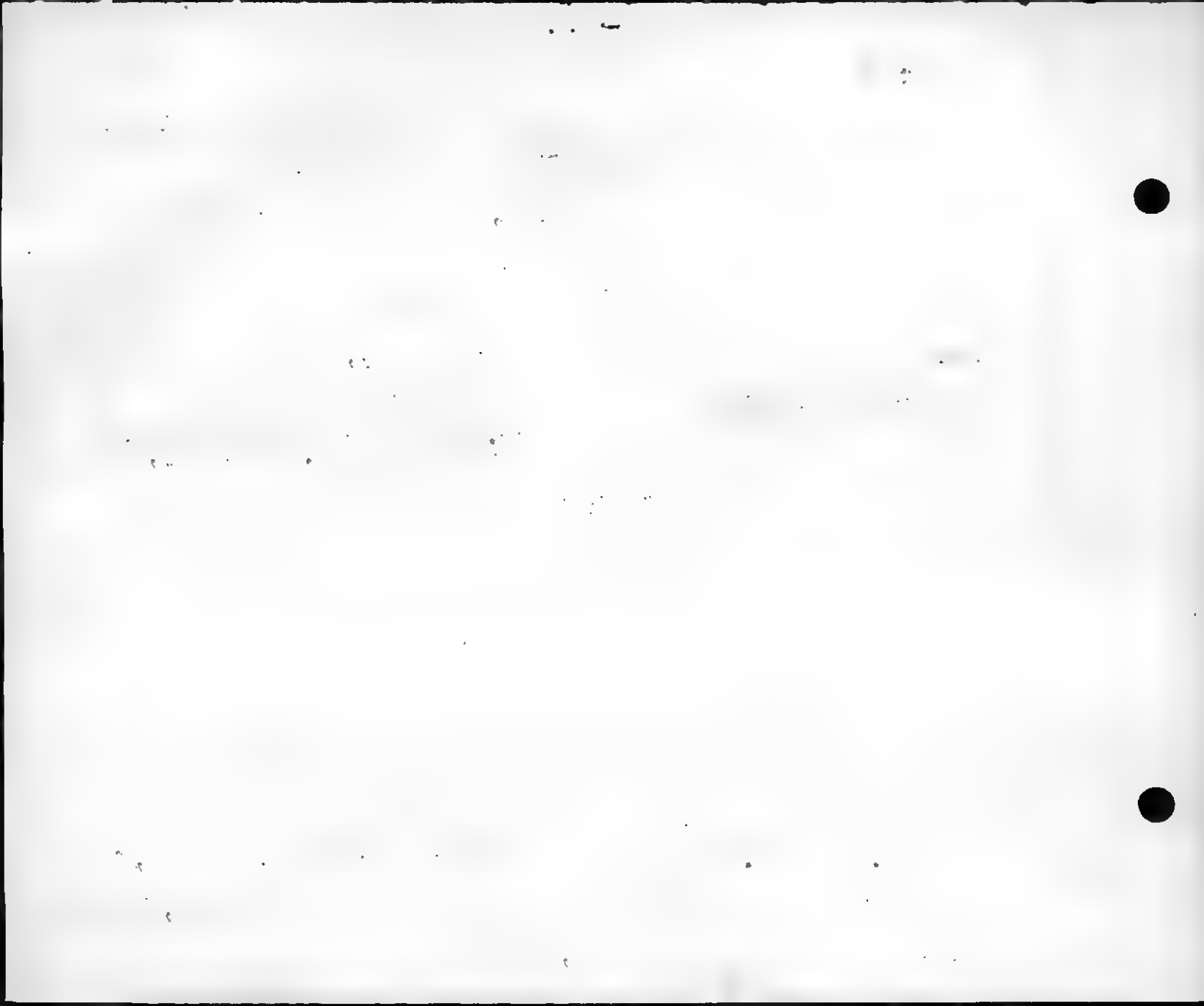
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
106882 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>811 Cooper Street</u>						
3. NAME OF DECEASED (Type or print) <u>JOHN DAVID HASTINGS</u>					4. DATE OF DEATH <u>JULY 27</u> 19 <u>66</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8/1966</u>		9. AGE (In years last birthday) <u>0</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>19</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Richard Lee Hastings</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Mae Kaiser</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Richard Lee Hastings (Father)</u> <u>811 Cooper St. Salisbury, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Congenital Anomalies</u> 7-11 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Imperforate anus -> Colostomy</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7/11/66</u> , to <u>7/27, 1966</u> , that (I) (we) last saw the deceased alive on <u>7/27, 1966</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/27/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. Daniel S. Anderson</u>					22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 29/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>					
24. FUNERAL DIRECTOR ADDRESS <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>AUG 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



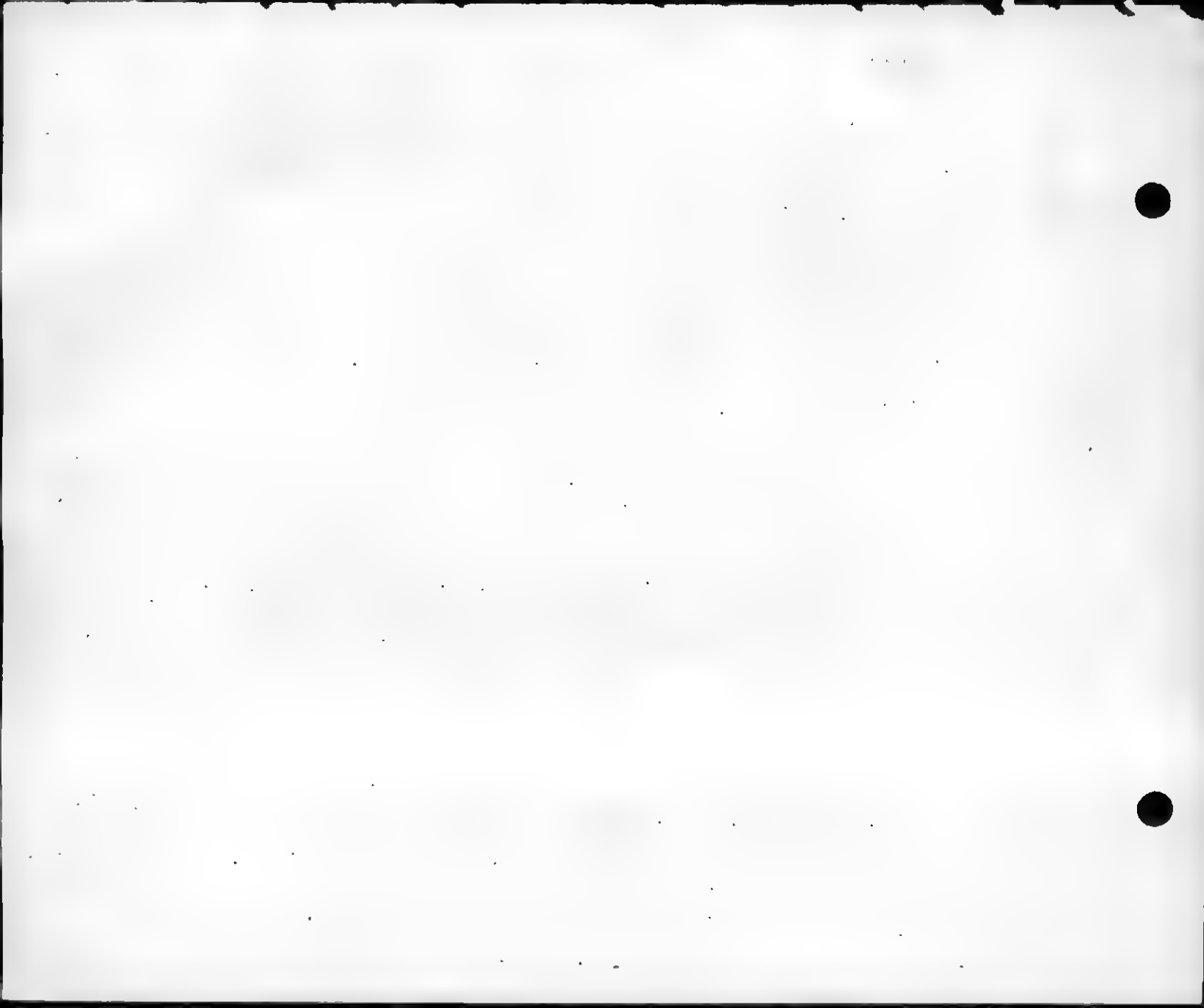
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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
106880						106883					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Wicomico</u>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>106880</u>			d. STREET ADDRESS <u>GIRDETREE</u>		
e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Paul</u>			4. DATE OF DEATH <u>July 22 1966</u>			5. SEX <u>Male</u>			6. AGE (in years last birthday) <u>60</u> yrs.		
7. COLOR OR RACE <u>White</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. DATE OF BIRTH <u>FEB 11, 1906</u>			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>			11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>PAUL HAUCK</u>						14. MOTHER'S MAIDEN NAME <u>CLARA H. GUTHMAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>505-10-1627</u>			17. INFORMANT <u>THEO R. HAUCK</u>			18. ADDRESS <u>GIRDETREE MD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Antropentone hemorrhage due to</u>											
DUE TO (b) <u>atherosclerotic tear in abdominal aorta</u>											
DUE TO (c) <u>@ level of Superior Mesenteric artery</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<u>Anteroposterior Aortic Aneurysm, Resection - intact Graft</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 4:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard E. Hughes</u>						22b. DATE SIGNED <u>7/27/66</u>			22c. PHYSICIAN'S NAME (Type) <u>RICHARD E. HUGHES MD</u>		
22d. ADDRESS <u>MEDICAL CENTER SALIS. MD.</u>						22e. REC'D BY REGISTRAR <u>Charles Judge</u>			22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7/23/1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>MAKEMIE PREBY</u>			23d. LOCATION (City, town or county) (State) <u>SNOW HILL, MD.</u>		
24. FUNERAL DIRECTOR <u>DEANIS Federal Home</u>			24b. ADDRESS <u>SNOW HILL, MD.</u>			25a. DATE <u>JUL 29 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

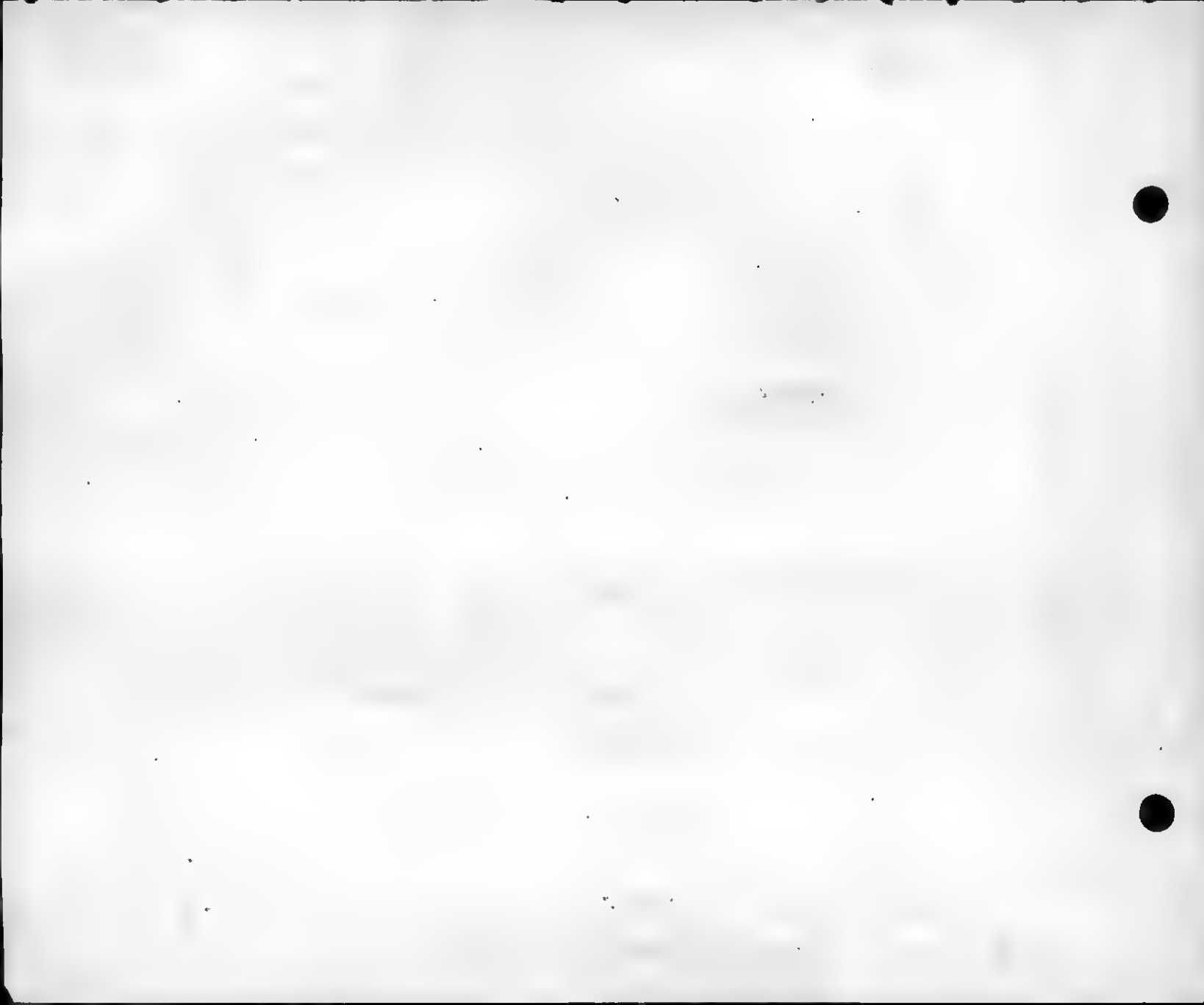


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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Mardela Springs</i> d. STREET ADDRESS <i>Rt. 1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Kim</i> Middle <i>Horton</i> Last <i>Horton</i> 4. DATE OF DEATH <i>July 3 1966</i>						5. SEX <i>Female</i> 6. COLOR OR RACE <i>negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>June 20, 1966</i> 9. AGE (in years last birthday) <i>- yrs.</i> IF UNDER 1 YEAR <i>Months</i> <i>Days</i> <i>Hours</i> <i>Min.</i> IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Wicomico</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Oris Horton</i>						14. MOTHER'S MAIDEN NAME <i>Gertrude Hopkins</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Oris Horton - Rt. 1 Mardela Springs Md</i> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <i>See</i> (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <i>6:30</i> AM, from the causes and on the date stated above.											
22a. SIGNATURE <i>William C. Morgan</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>7-6-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion</i>			23d. LOCATION (City, town or county) (State) <i>Mardela Springs Md.</i>			
24. FUNERAL DIRECTOR <i>Loretta B. Jolley, Jersey Rd, Salis, Md</i> ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>J. Carter Jones</i>			
DATE <i>JUL 13 1966</i>											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

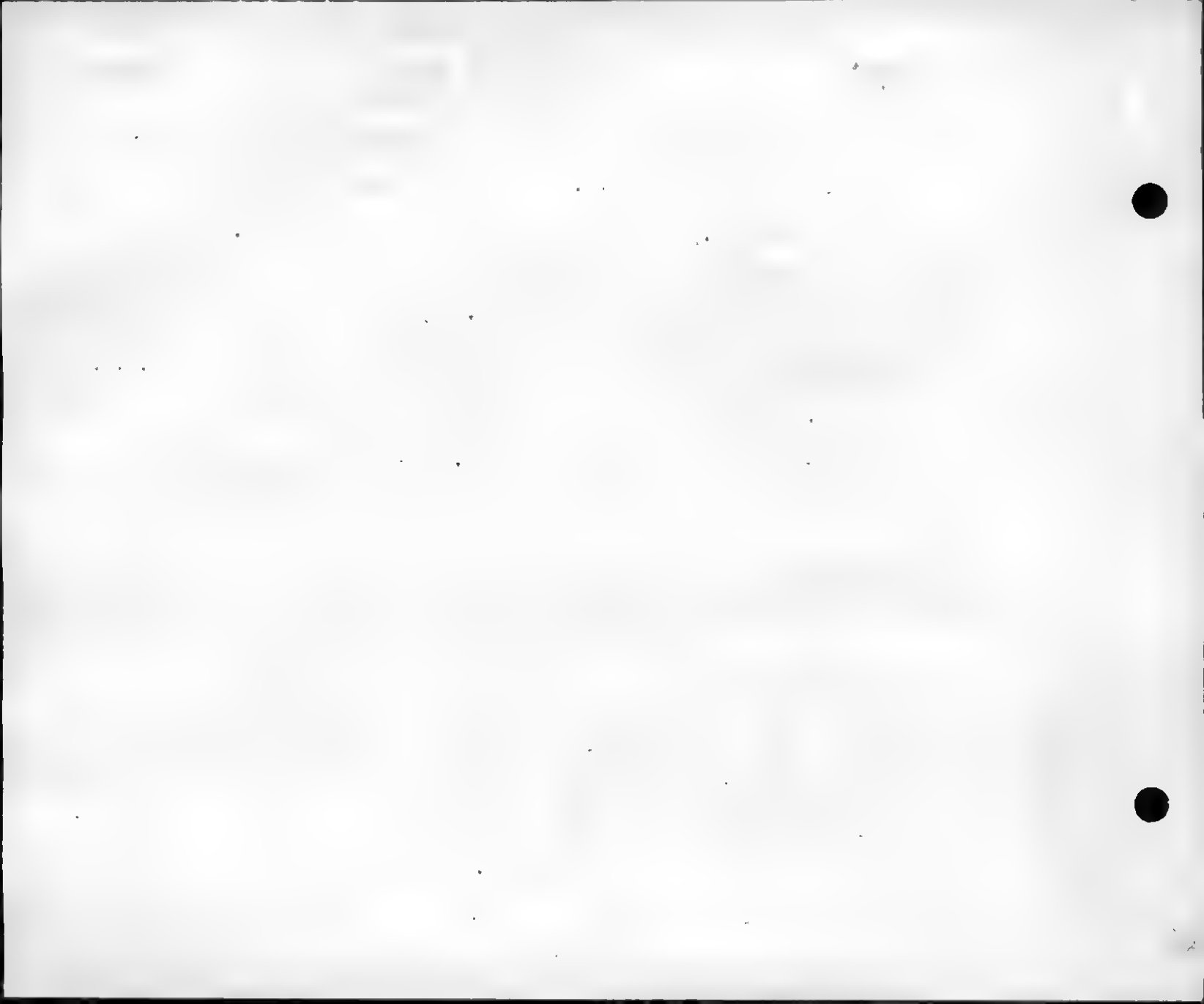
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CERTIFICATE OF DEATH

10685

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>415 Pine Bluff Rd.,</u>				d. STREET ADDRESS <u>415 Pine Bluff Rd.,</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last <u>Esther Elizabeth Hearne</u>				4. DATE OF DEATH Month Day Year <u>7 23 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1872</u>		9. AGE (in years, months, days) <u>93</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clayton C. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Maria Jane Leonard</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Miss. Elizabeth Hearne, Same</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1958</u> to <u>July 23 1966</u> , that (I) (we) last saw the deceased alive on <u>July 22 1966</u> , and that death occurred at <u>5:45</u> AM, from causes and on the date stated above									
22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED <u>7/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL JR. MD</u>								22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-25-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Thomas F. Baker</u> Salisbury, Maryland						25a. REC'D BY REGISTRAR DATE <u>JUL 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10693

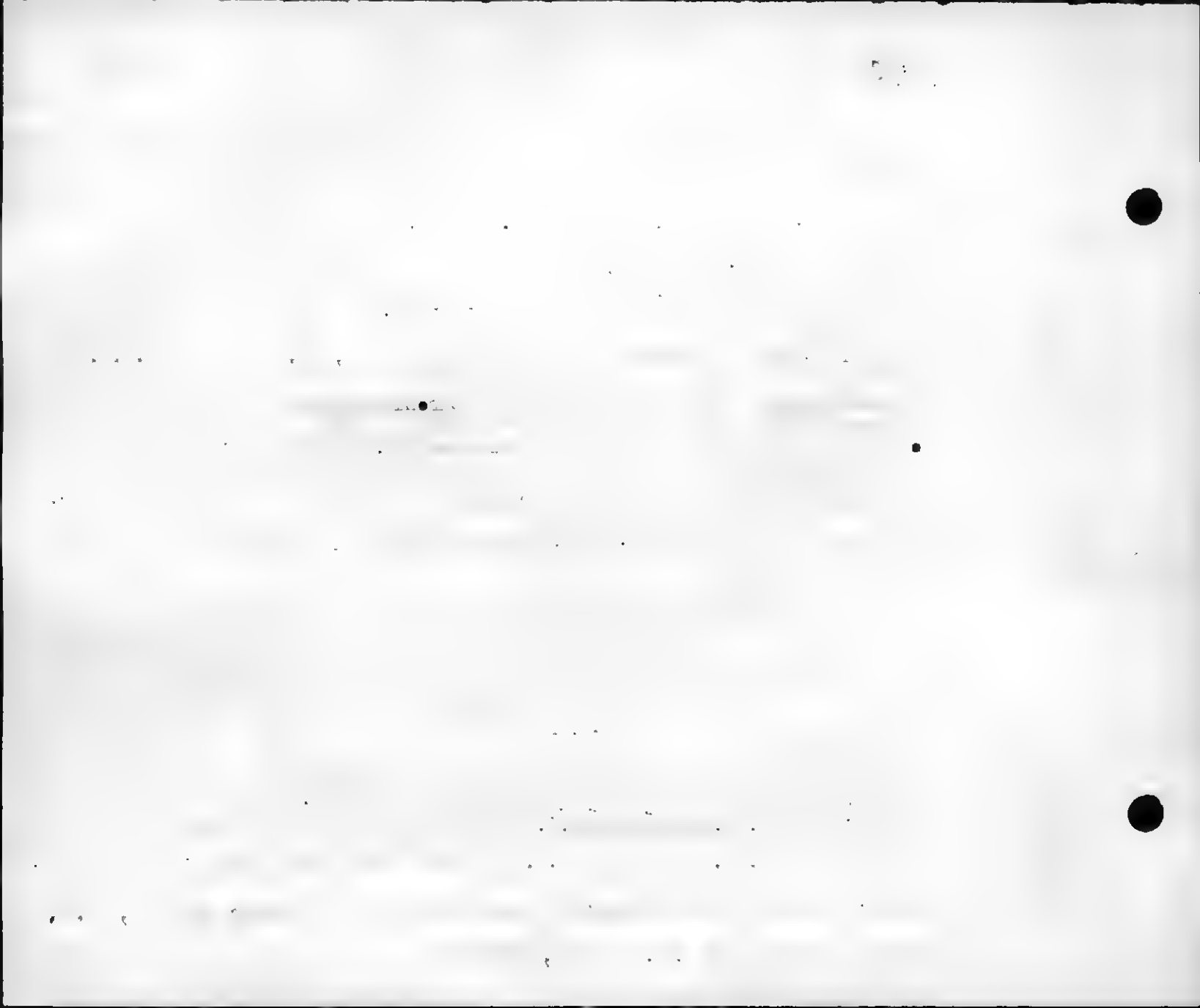
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10680

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 55 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Preston		d. STREET ADDRESS R. D. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Clifford Arthur Henney		4. DATE OF DEATH Month 7 Day 18 Year 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-24-1899		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Bernhard Henney		14. MOTHER'S MAIDEN NAME Caroline Knemeyer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Henney		Address same as #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary carcinoma of lung, rt. upper lobe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH hrs. years ?		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 5/24 , 19 66 , to 7/18 , 19 66 , that (I) (we) last saw the deceased alive on 7/18 , 19 66 , and that death occurred at 11:35 from the causes and on the date stated above.														22a. SIGNATURE C. H. Winnacott, M.D.		22b. DATE SIGNED 7/19/66							
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M.D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.		22e. MED. DIRECTOR <input type="checkbox"/>		22f. STAFF PHYS. <input checked="" type="checkbox"/>		22g. DATE SIGNED 7/19/66		22h. SIGNATURE Charles Judge		22i. ADDRESS Deer's Head State Hospital, Salisbury, Md.		22j. MED. DIRECTOR <input type="checkbox"/>		22k. STAFF PHYS. <input checked="" type="checkbox"/>		22l. DATE SIGNED 7/19/66					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 23/66		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park		23d. LOCATION (City, town or county) (State) Camden County, N.J.		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		24a. ADDRESS SALISBURY, MARYLAND		24b. REC'D BY REGISTRAR JUL 22 1966		24c. REGISTRAR'S SIGNATURE Charles Judge		24d. ADDRESS Deer's Head State Hospital, Salisbury, Md.		24e. MED. DIRECTOR <input type="checkbox"/>		24f. STAFF PHYS. <input checked="" type="checkbox"/>		24g. DATE SIGNED 7/19/66	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

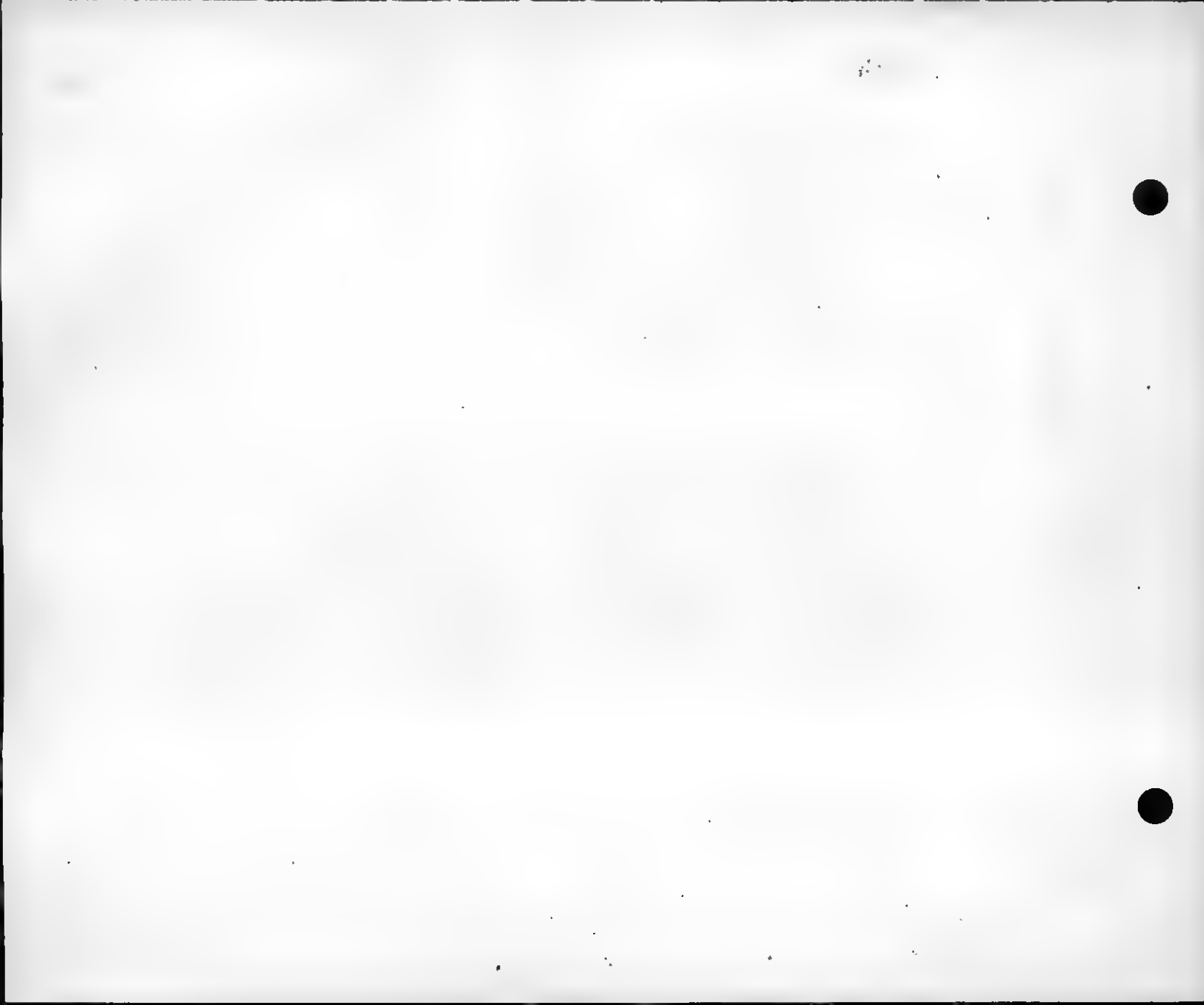
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10094

10687

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>White Haven</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.F.D. 1 box 38 Tyaskin</u>			
3. NAME OF DECEASED (Type or print) <u>JULIA</u>		First Middle Last		4. DATE OF DEATH <u>JULY 22 1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1914</u>	
9. AGE (in years last birthday) <u>52 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. ACE (in years last birthday) Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Carr Handy</u>				14. MOTHER'S MAIDEN NAME <u>Julia Conway</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nesley Horsey Tyaskin Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma to brain</u> X DUE TO (b) <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-15-</u> , 19 <u>66</u> , to <u>7-22-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-22-</u> , 19 <u>66</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. Coffey</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury MD</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7/26/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>New Town Md.</u>	
24. FUNERAL DIRECTOR <u>Clinton F. Stewart Salisbury Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

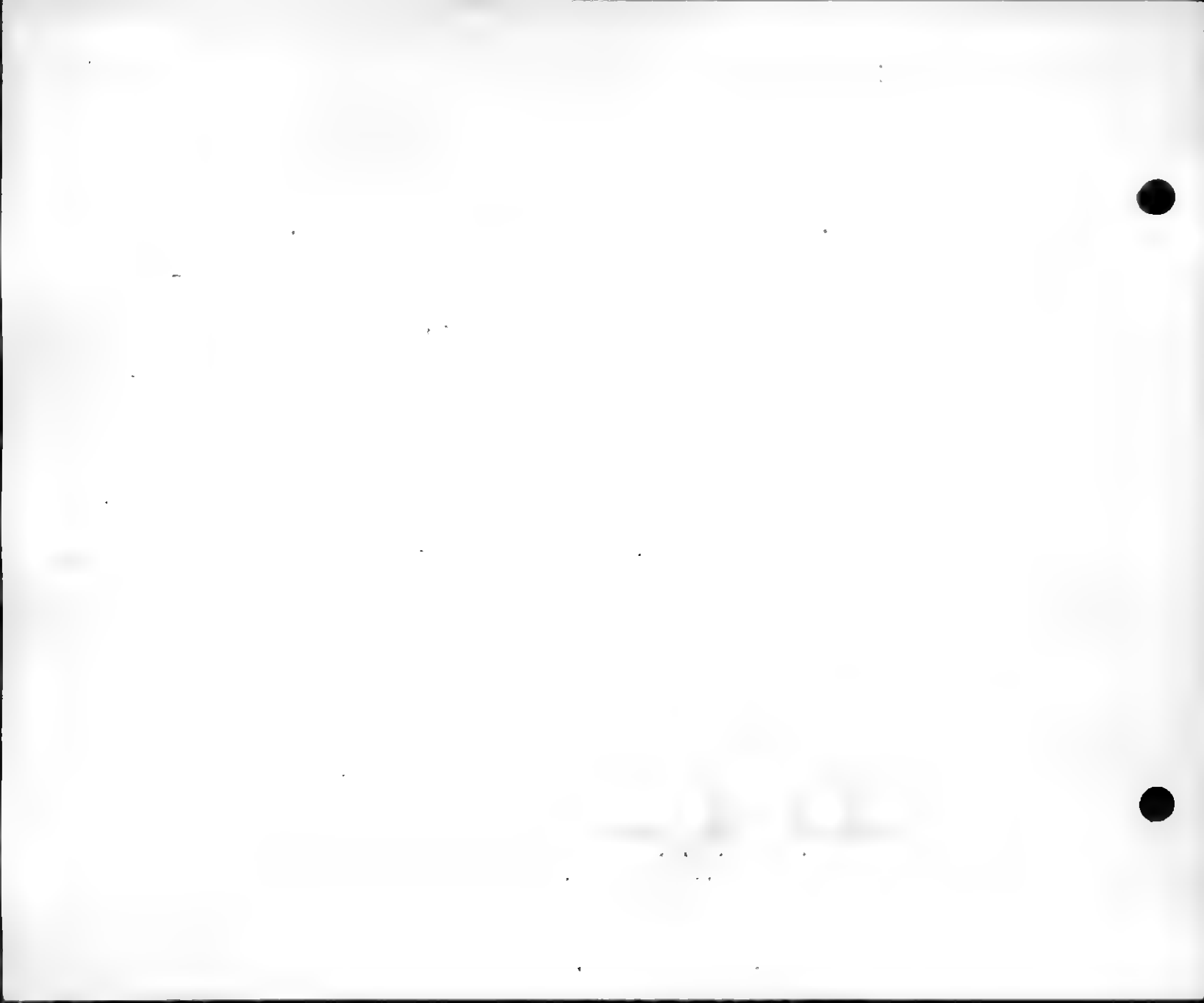
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10688

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pennsylvania b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY N 1b		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Chester		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 715 N. Westover Circle				d. STREET ADDRESS 224 Law St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMMY Middle JAMES Last HORSEY				4. DATE OF DEATH Month 7 Day 24 Year 1966			
5. SEX Male	6. CO. OR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1891	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months 7 Days 24		IF UNDER 24 HRS Hours 19 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Horsey				14. MOTHER'S MAIDEN NAME Mary Savage			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 716-12-2486		17. INFORMANT Sammy Horsey		Address 715 Westover Cir. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic cardio-vascular disease DUE TO (b) Years (c)						INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				22. DATE SIGNED July 26, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/1966		23c. NAME OF CEMETERY OR CREMATORY Hopewell		23d. LOCATION (City or Town) (County) (State) Hopewell Md.	
24. FUNERAL DIRECTOR Clinton Stewart, Salisbury, Md. <i>Clinton Stewart</i>				25a. REC'D BY REGISTRAR DATE AUG 1 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

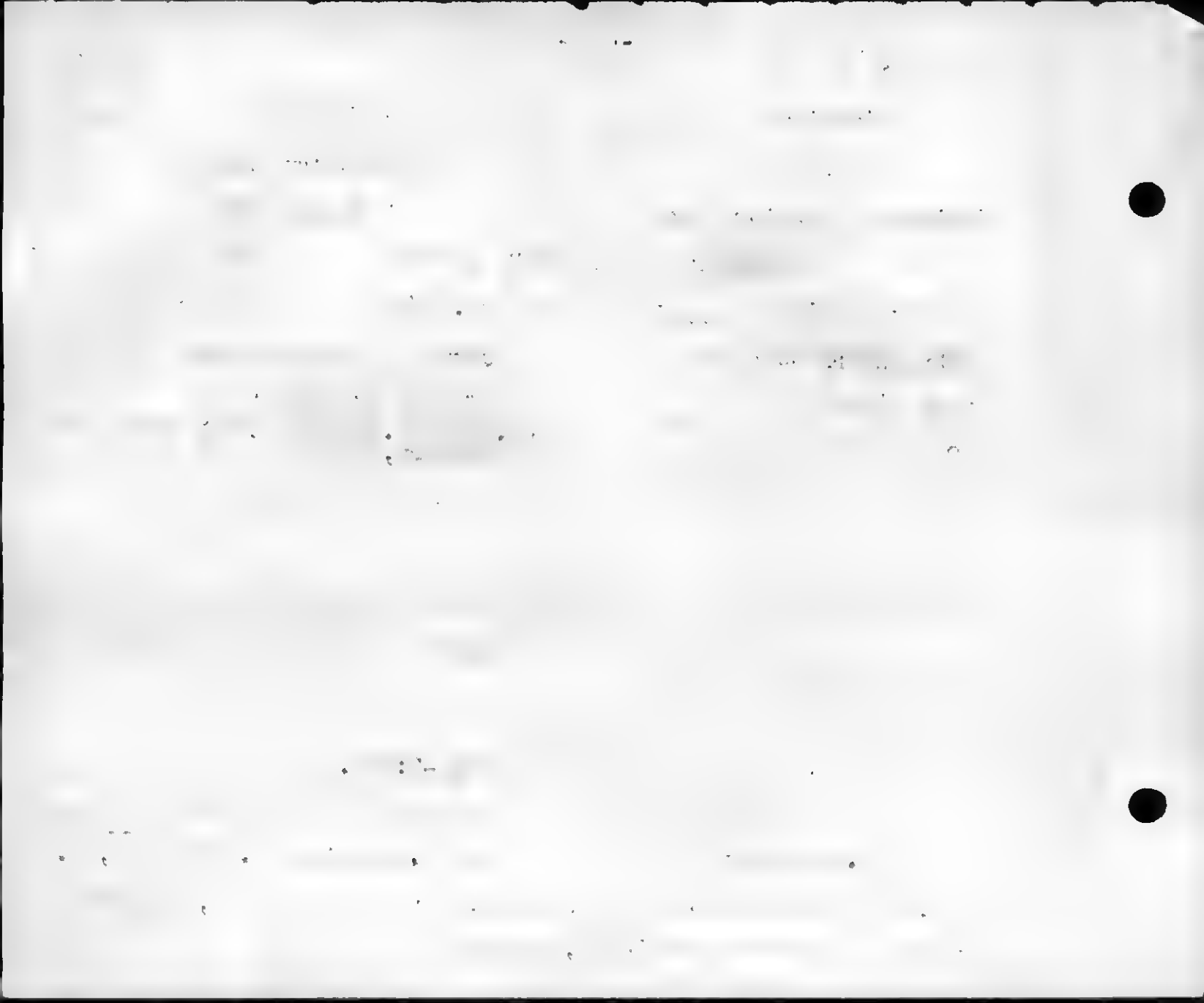
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(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH-AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10689

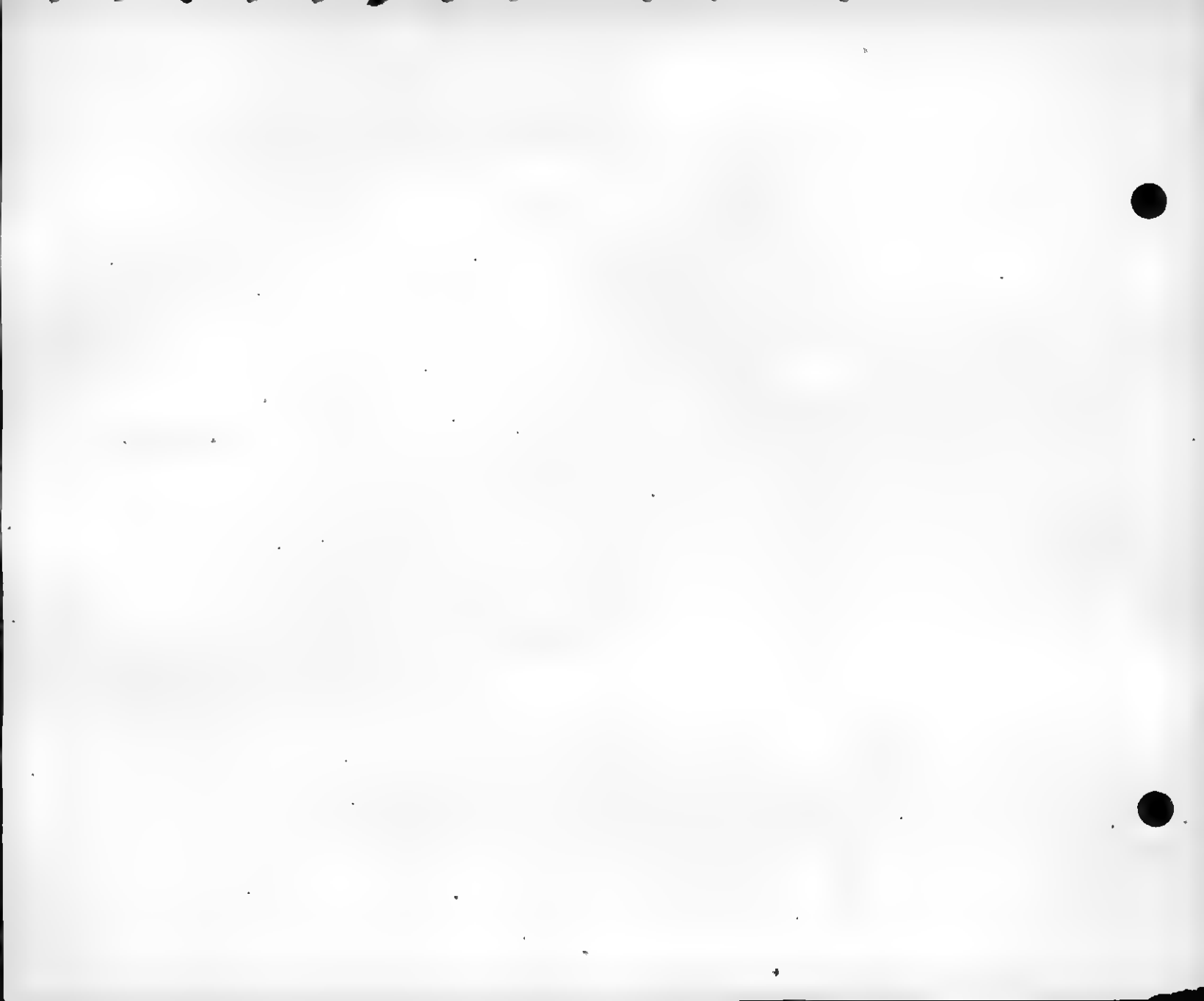
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Salisbury (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springhill Nursing Home				d. STREET ADDRESS Mt Hermon Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HENRIETTA ELIZABETH HOTTON				4. DATE OF DEATH Month JULY Day 5th Year 19 66			
5. SEX Female				6. COLOR OF RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Aug. 2/1879			
9. AGE (in years last birthday) 86 yrs.				10. IF UNDER 1 YEAR Months 11 Days 3 Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Guernsey Island England			
11. BIRTHPLACE (County & State, or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Girard				14. MOTHER'S MAIDEN NAME Mary Ann LeTissier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Mr. Cecil G. Hotton (Son)			
17. INCORPORATED Salisbury, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cerebral Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 				20f. (City or town) (County) (State) 			
21. I certify that (I) (this hospital) attended the deceased from Aug-7-53A to , 19 , that (I) (we) last saw the deceased alive on , 19 , and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Lee Lawry				22b. DATE SIGNED July 6/1966			
22c. PHYSICIAN'S NAME (Type) Dr. Lee Lawry				22d. ADDRESS 315 N. Division St. Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 7/1966			
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery				23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR JUL 11 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																							
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SELBYVILLE</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>VINA</u> Middle <u>A.</u> Last <u>HUDSON</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1966</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												
8. DATE OF BIRTH <u>7-7-1877</u>			9. AGE (in years last birthday) <u>89</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.					10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED STEELER</u> 10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																					
Months	Days	Hours	Min.																				
13. FATHER'S NAME <u>JAMES DERRICKSON</u>						14. MOTHER'S MAIDEN NAME <u>SALUE LEKITES</u>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>221-24-478</u>			17. INFORMANT <u>ALBERT HUDSON, SELBYVILLE, Del.</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> (b) <u>Heart Disease</u> (c) </div> <div style="width: 15%; text-align: center;"> DUE TO (b) DUE TO (c) </div> <div style="width: 5%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> </div> </div>																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from <u>7-13-66</u> to <u>7-13-66</u> that (I) (we) last saw the deceased alive on <u>7-13-66</u> and that death occurred at <u>11 AM</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>William R. McClellan</u>						22b. DATE SIGNED <u>7-15-66</u>			22c. PHYSICIAN'S NAME (Type) <u>William R. McClellan</u>														
22d. ADDRESS <u>Trunkford, Del.</u>						22e. REC'D BY REGISTRAR			22f. REGISTRAR'S SIGNATURE <u>James Nelson</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LYNCHES CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>SELBYVILLE, DEL.</u>															
24. FUNERAL DIRECTOR <u>James Nelson, Trunkford, Del.</u>																							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10698

10691

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c LENGTH OF STAY in lb Since 9/10/65		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital				d STREET ADDRESS RFD #1		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Frank Middle Talbert Last Irby				4 DATE OF DEATH Month July Day 3 Year 19 66			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH June 14, 1897	
9 AGE (in years last birthday) 69		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Campbell Co., Virginia	
12 CITIZEN OF WHAT COUNTRY? USA				13 FATHER'S NAME Isaiah Irby			
14. MOTHER'S MAIDEN NAME Alice Holmes				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 228-03-3037				17 INFORMANT Records of Pine Bluff State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1965 to July 3, 1966 , that (I) (we) last saw the deceased alive on July 3, 19 66 , and that death occurred at 10:50 A.M. causes and on the date stated above.							
22a. SIGNATURE <i>E. P. Ritchings</i>				22b. DATE SIGNED July 3, 1965		22c. PHYSICIAN'S NAME (Type) E. P. Ritchings	
22d. ADDRESS Pine Bluff State Hospital,				22e. ADDRESS Salisbury, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF July 6, 1966		23c NAME OF CEMETERY OR CREMATORY Crumpton Cemetery		23d. LOCATION (City or Town) (County) (State) Crumpton, Q.A.Co; Md.	
24. FUNERAL DIRECTOR Edward Fellows, Millington, Md.				25a. REC'D BY REGISTRAR DATE JUL 7 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

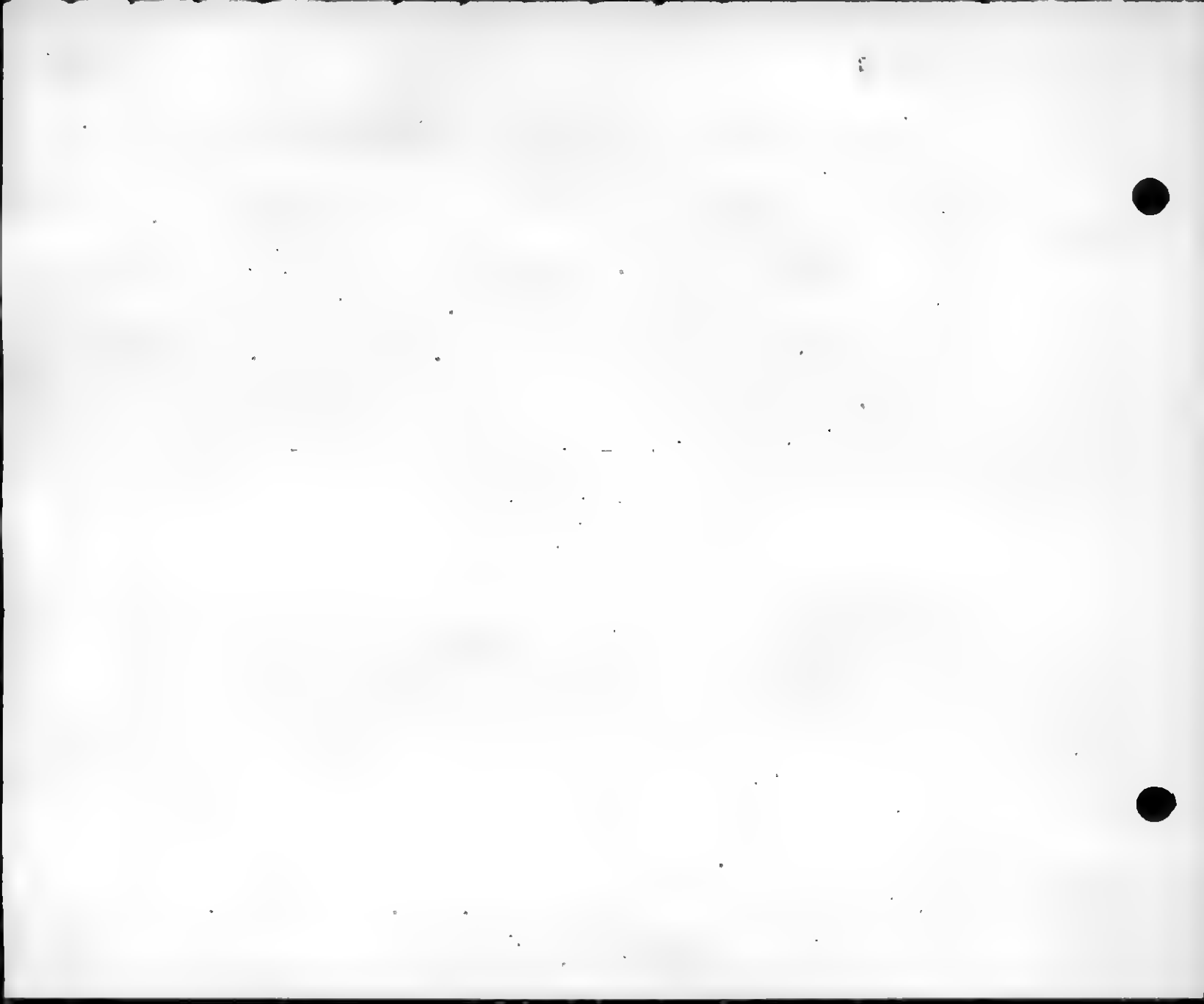
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10693

10692

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Arlington</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>833</i> d. STREET ADDRESS <i>638 North Greenbrier St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Erroll R. Jenkins</i>		4. DATE OF DEATH <i>July 30 1966</i>		5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 24, 1918</i> 9. AGE (In years, last birthday) <i>48</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Funeral Director</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Funeral</i>		11. BIRTHPLACE (County & State, or foreign country) <i>St. Clair, Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Ralph B. Jenkins</i>				14. MOTHER'S MAIDEN NAME <i>Martha Crestwell</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes give war or dates of service) <i>WW II</i>		16. SOCIAL SECURITY NO. <i>165-18-3675</i>		17. INFORMANT <i>Mary Lou Jenkins- Same as #2</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> DUE TO (b) <i>Cerebral Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus. Arteriosclerotic Heart Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7/29</i> , 19 <i>66</i> , to <i>7/30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/29</i> , 19 <i>66</i> , and that death occurred at <i>1:45</i> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>David J. Gilmore</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>David J. Gilmore</i>	
23a. BIRTH, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<i>Burial</i>		<i>8/2/66</i>		<i>Arlington Nat. Cem.</i>		<i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>Harold F. Murphy</i>				25a. REC'D BY REGISTRAR <i>AUG 3 1966</i>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	
ADDRESS <i>Murphy Funeral Home</i>				ADDRESS <i>Arlington, Virginia</i>			



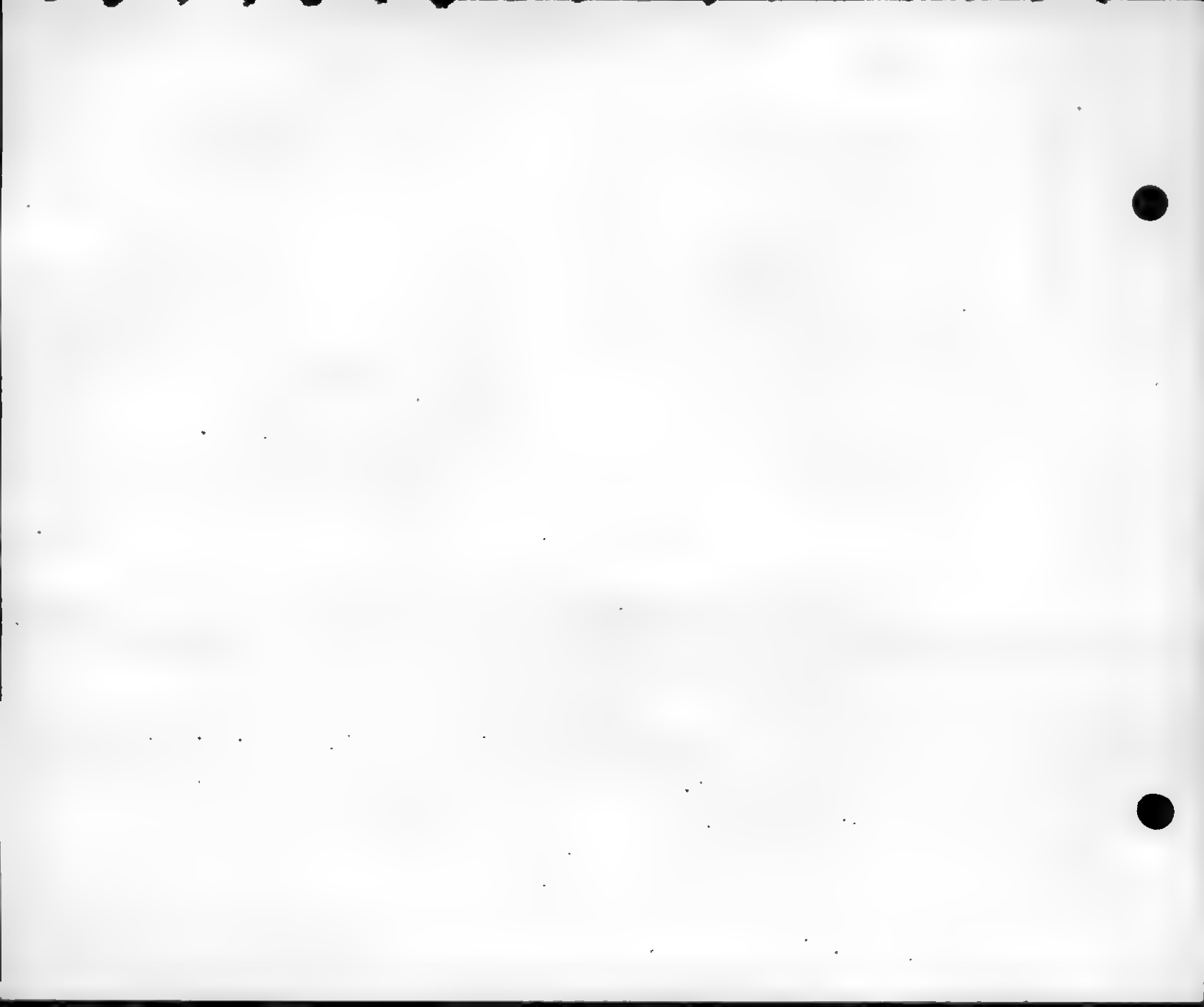
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Upon please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B-7

VR A15 (4)
2DM 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Peninsula General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>_____</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Ralph</u> <u>S</u> <u>Jones</u>			4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>Negro</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John Jones</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>_____</u>						17. INFORMANT <u>Marna Hubbard</u> Address <u>_____</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism.</u> DUE TO (b) <u>Phlebotrombosis</u> DUE TO (c) <u>_____</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>3 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma Stomach</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>_____</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>7/11/66</u> to <u>7/14/66</u> that (I) (we) last saw the deceased alive on <u>7/14/66</u> and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>[Signature]</u>												22b. DATE SIGNED <u>_____</u>					
22c. PHYSICIAN'S NAME (Type) <u>D. Burton M.D.</u>												22d. ADDRESS <u>_____</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7-17-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Loretta Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Loretta Md.</u>					
24. FUNERAL DIRECTOR <u>Decker M. West</u>												25a. REC'D BY REGISTRAR DATE <u>JUL 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10701 Item 2 See Birth Cert.					10694				
1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Worcester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 204 Broad Street				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH			4. DATE OF DEATH Month Day Year JULY 20 1966						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 20 1966		9. AGE (In years last birthday) - yrs. - Months - Days - Hours - Min. - - - 3 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) SALISBURY MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Bobby JOSEPH					14. MOTHER'S MAIDEN NAME CLARA L. PERDUE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Bobby JOSEPH Berlin MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 116X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 3:40 M, from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED JUL 25 1966				
22c. PHYSICIAN'S NAME (Type) DANIEL ANDERSON					22d. ADDRESS [Address]				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/22/66		23c. NAME OF CEMETERY OR CREMATORY NEW HOPE		23d. LOCATION (City, town or county) (State) WILLARDS MD			
24. FUNERAL DIRECTOR Anna A. Burboze Berlin Md					25a. REC'D BY REGISTRAR DATE JUL 25 1966		25b. REGISTRAR'S SIGNATURE [Signature]		

6-220146



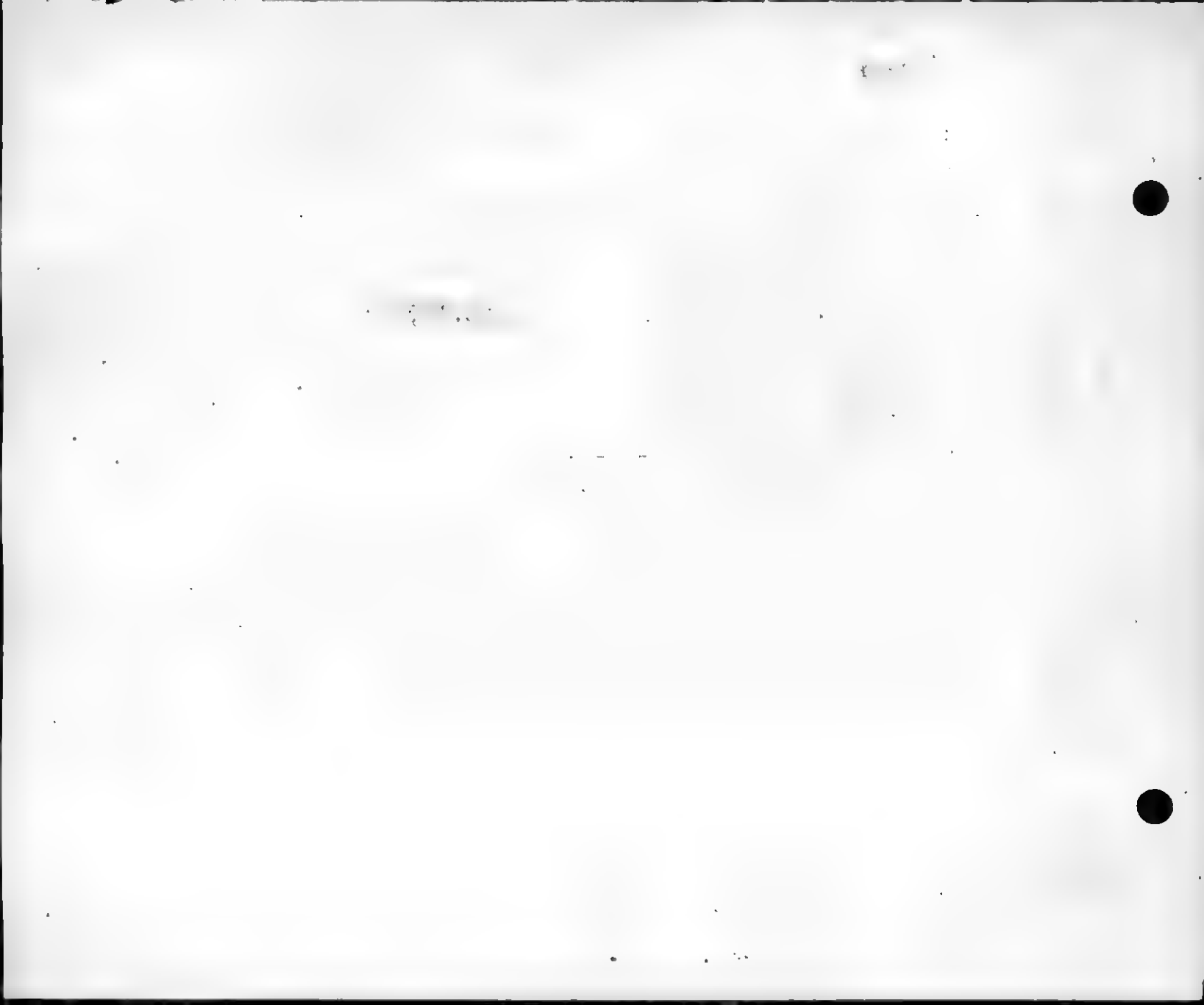
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B.P.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

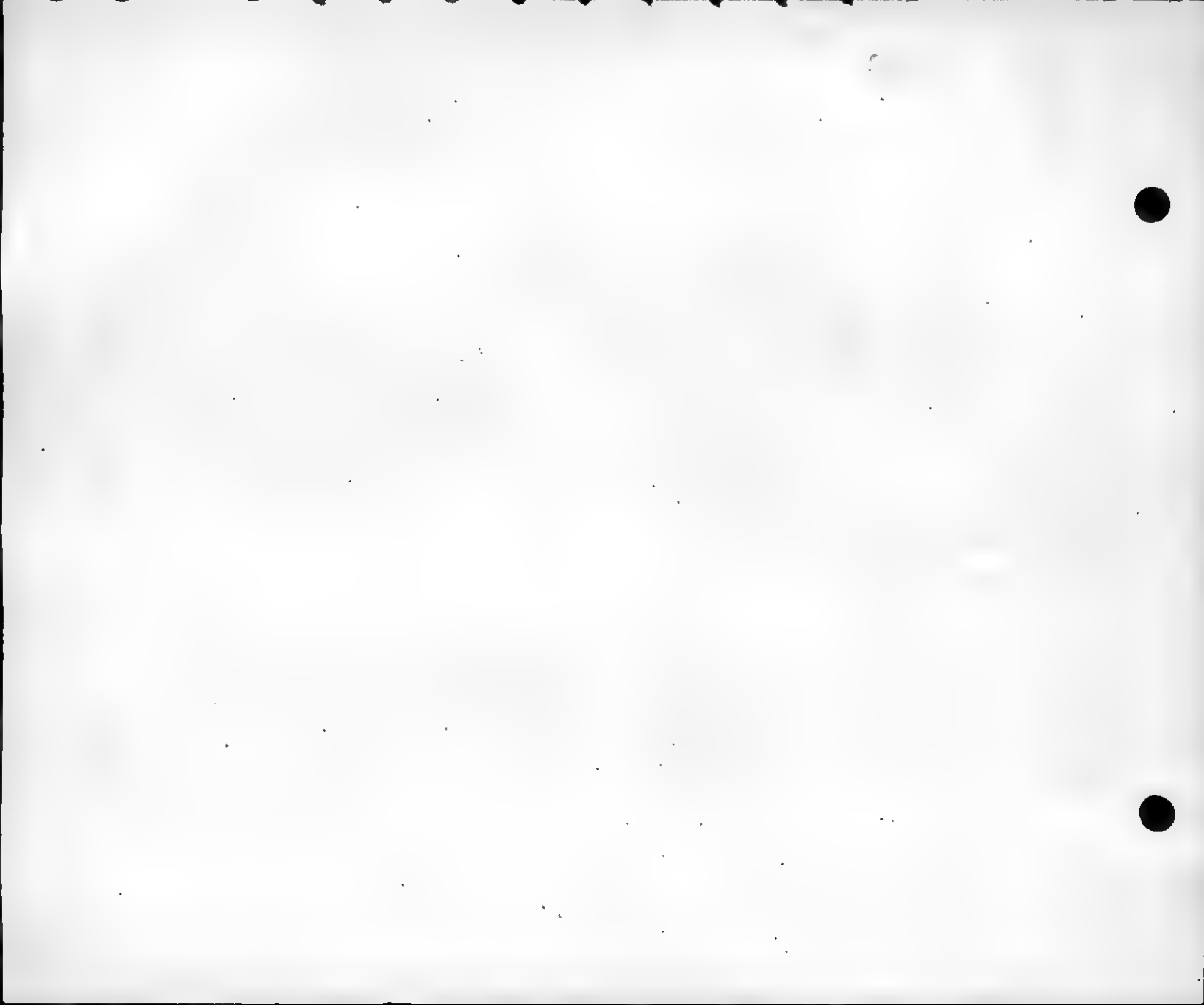
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Happy Lane 313</u>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>E.</u> Last <u>King</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1880</u>
9. AGE (in years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Sanford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-6746</u>	
17. INFORMANT <u>Louise Carter</u>		Address <u>2227 Wharton St. Phila. Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.A. (large)</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebro Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/9/66</u> , 19 <u>66</u> , to <u>7/19/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/19/66</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Carrie Hearn</u> M.D.		22b. DATE SIGNED <u>7/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARRIE HEARN MD</u>		22d. ADDRESS <u>226 N. DuPont St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/24/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury Md.</u>
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u>		25a. REC'D BY REGISTRAR <u>Salisbury Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 27 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
10703														
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>					d. STREET ADDRESS <u>705 JEWEL STREET</u>									
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>KIRK</u> Last <u>KIRK</u>					4. DATE OF DEATH Month <u>JULY</u> Day <u>16</u> Year <u>1966</u>									
5. SEX <u>FEMALE</u>					6. COLOR OR RACE <u>WHITE</u>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>9-14-50</u>									
9. AGE (In years last birthday) <u>55</u> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>									
11. BIRTHPLACE (County & State, or foreign country) <u>DELMAR-DEL</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>JOSEPH BEACH</u>					14. MOTHER'S MAIDEN NAME <u>SARAH ELLIS</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>—</u>									
17. INFORMANT Address <u>SARAH BANKS DELMAR-DEL</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>66</u> , to <u>7/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/16</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.										22b. DATE SIGNED				
22a. SIGNATURE <u>David J. Gilmore</u>										22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>				
22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>										23b. DATE THEREOF <u>7-18-66</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>ST STEPHENS CEM</u>										23d. LOCATION (city, town or county) (State) <u>DELMAR-DEL</u>				
24. FUNERAL DIRECTOR <u>Charles W. Harrell - Delmar, Del</u>										25a. REC'D BY REGISTRAR <u>JUL 18 1966</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

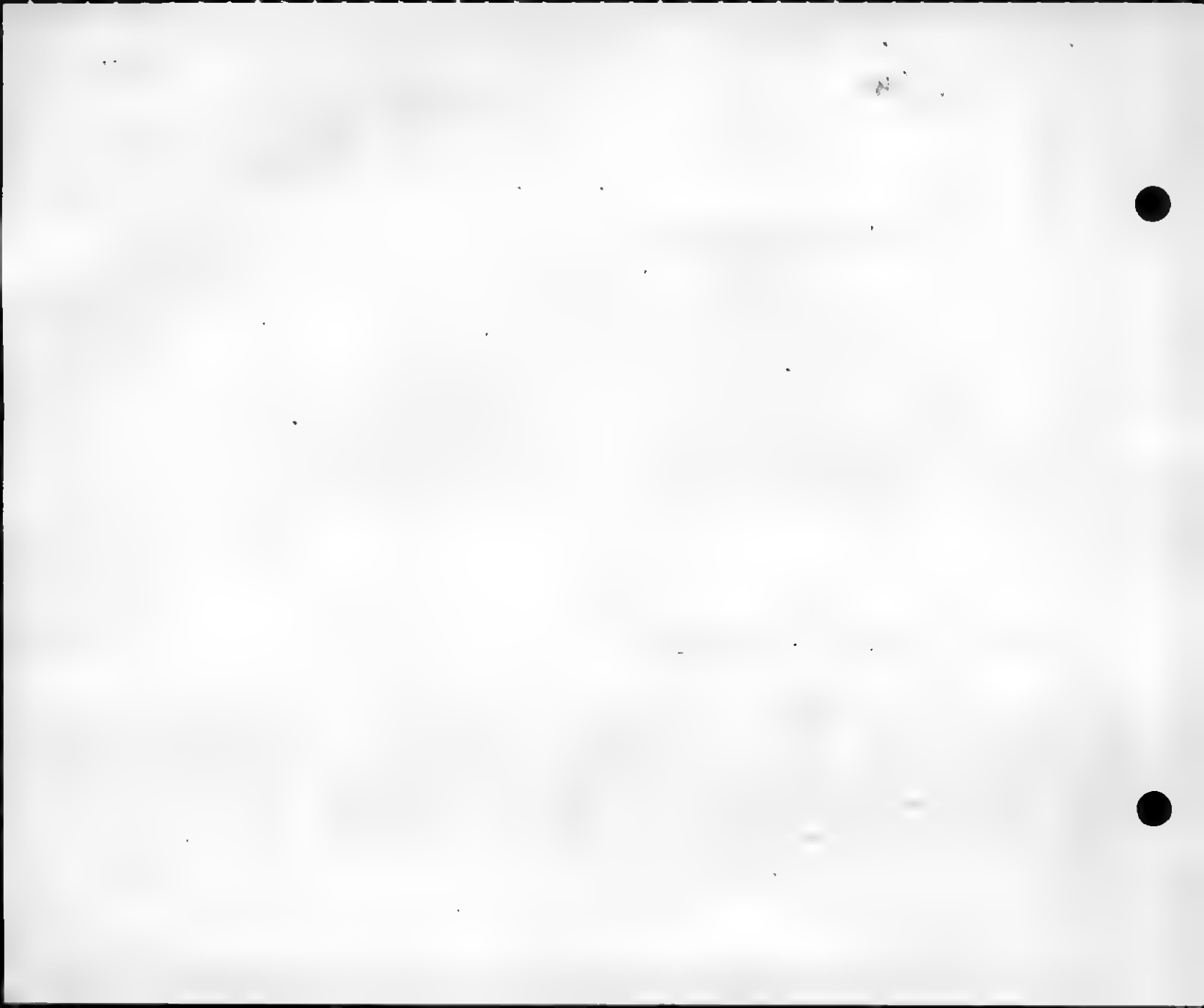
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10704

10697

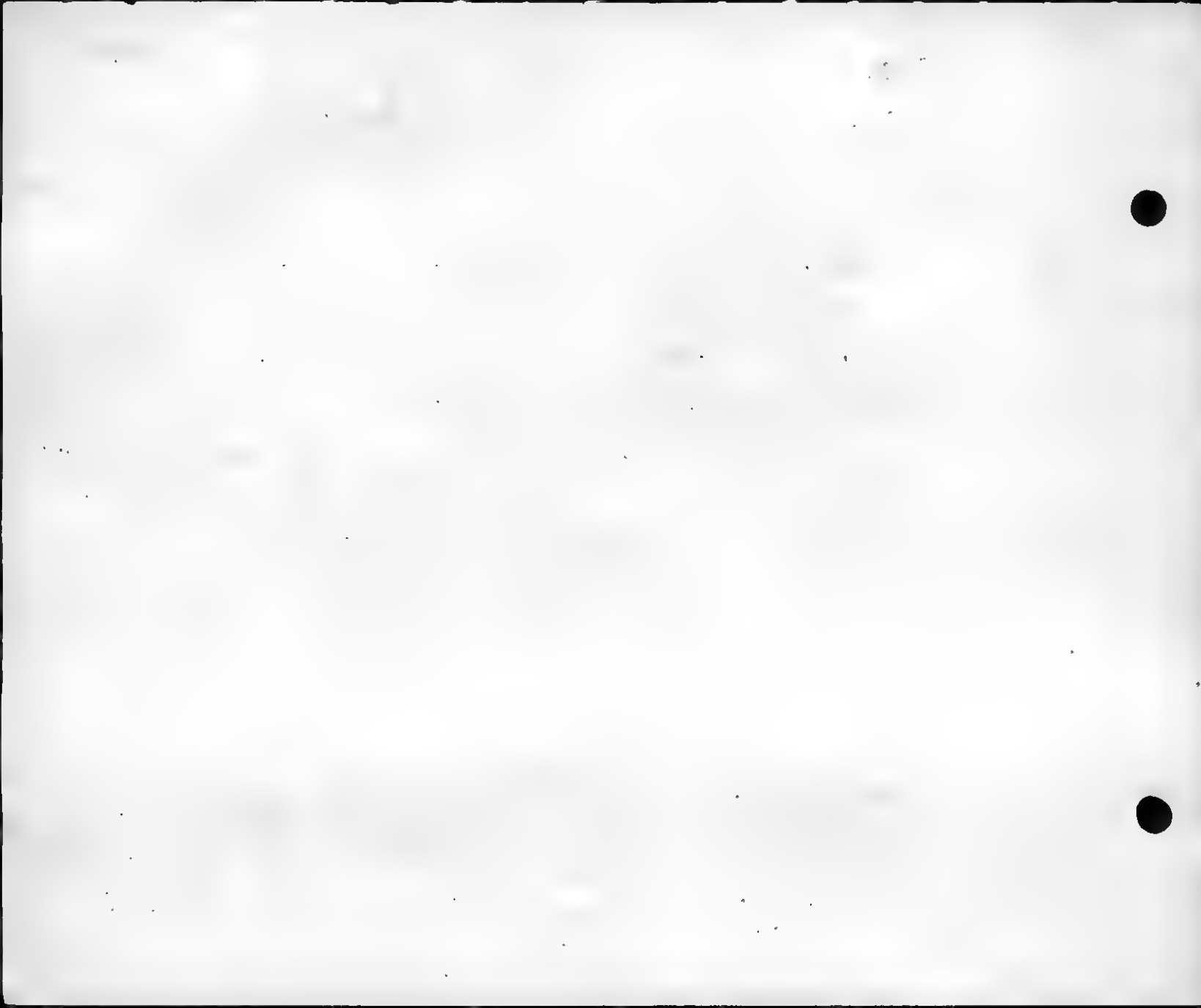
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>9 yrs. 10 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u> <u>07-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Hannah</u> Last <u>Kral</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8/30/1909</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kral</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Moyer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Louis Kral, East New Market, Md</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis - years</u>						19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>0.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>56</u> , to <u>July 31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>66</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>C.H. Winnacott</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.H. Winnacott, M.D.</u>				22d. ADDRESS <u>Deer's Head State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer's Head State Hospital</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury Md</u>	
24. FUNERAL DIRECTOR <u>John S. Milborough, East New Market, Md</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film G379 7/26/66											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Seaford</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seaford Rural</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Eugene H. Lankford</u>						4. DATE OF DEATH <u>July 14 1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 21-1897</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Seaford Del.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Lankford</u>						14. MOTHER'S MAIDEN NAME <u>Annie Pusy</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>221-244063</u>		17. INFORMANT <u>Mrs Elva H. Lankford, Seaford, Del</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion - atherosclerosis</u> DUE TO (b) <u>Aortic aneurysm</u> DUE TO (c) <u>Abdominal</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6:17</u> , 19 <u>66</u> to <u>7:14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7:14</u> , 19 <u>66</u> and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>H. H. Briele</u>						22b. DATE SIGNED <u>7-16-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>						22d. ADDRESS <u>Medical Center Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 18-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Seaford Del</u>			
24. FUNERAL DIRECTOR <u>Harry E. Darby Seaford, Del</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>					
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
						DATE <u>JUL 19 1966</u>					



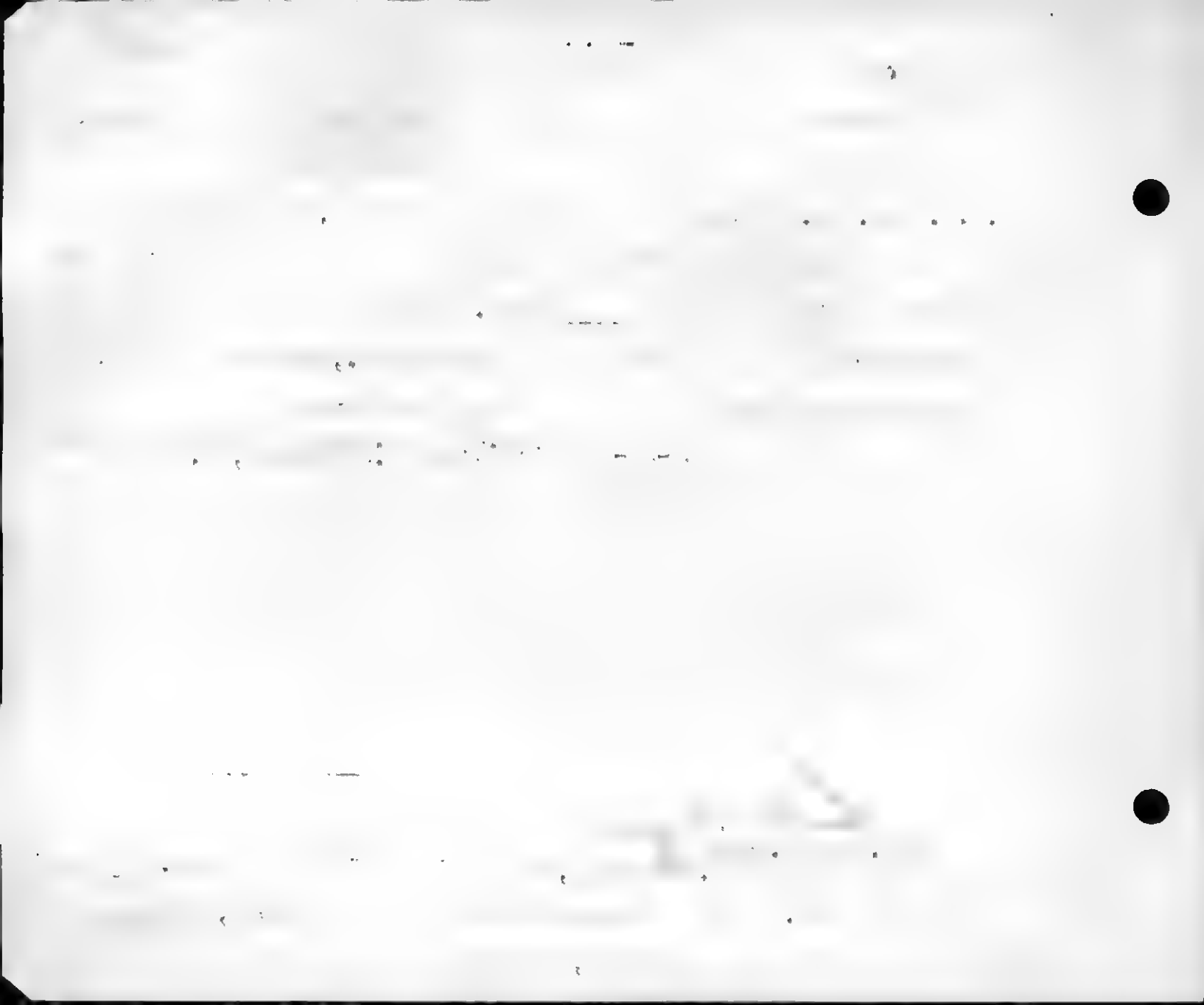
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 13&21 Film 379 8-3-66 ams
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Pen.Gen.Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 1904 N.Salisbury Blvd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PEARL Middle MATILDA Last LAYFIELD		4. DATE OF DEATH Month JULY Day 31 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Apr. 28/1918
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR: Months 3 Days 03 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Henry Ellis		14. MOTHER'S MAIDEN NAME Annie Bell Dykes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-9722	
17. INFORMANT Mrs. Edith E. Hubeny (Sister)		Address 1109 North Division St. Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		22. DATE SIGNED Aug. 2/1966	
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 3/1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR AUG 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

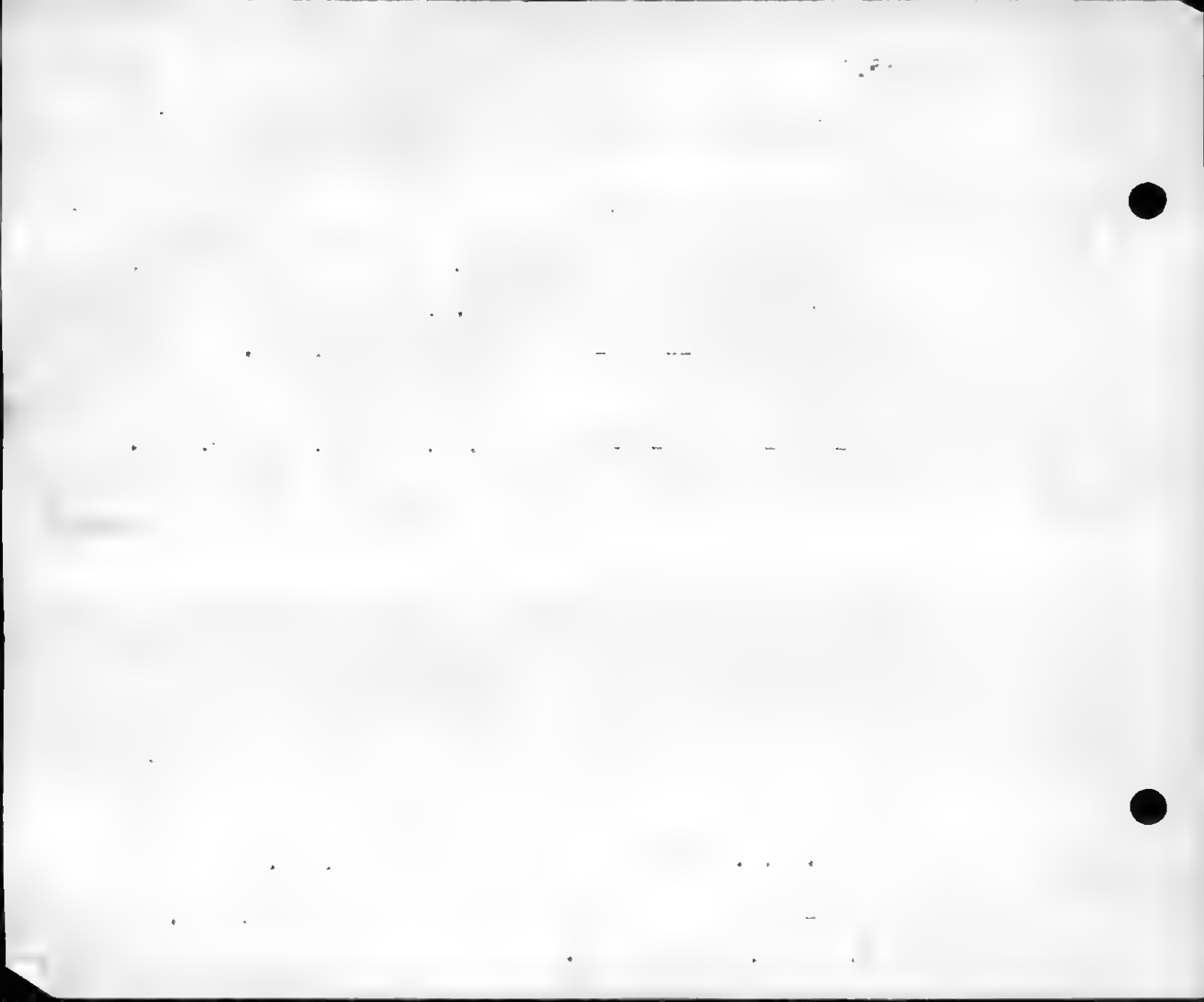


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mapleshade Convalescent Home					d. STREET ADDRESS Rt # 1					
3. NAME OF DECEASED (Type or print) JENNIE LECATES					4. DATE OF DEATH July 7, 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 1, 1888		9. AGE (In years last birthday) 78 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home					10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Whitesville, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Cordrey					14. MOTHER'S MAIDEN NAME Ella Carmine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-34-7386		17. INFORMANT Wm. J. LeCates, Delmar, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 6 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 24, 1966 , to July 7, 1966 , that (I) (we) last saw the deceased alive on 7/7/66 19, and that death occurred at 4:30 PM , from the causes and on the date stated above.										
22a. SIGNATURE H.S. Kuhlman					22b. DATE SIGNED 7/9/66		22c. PHYSICIAN'S NAME (Type) Dr. H.S. Kuhlman			
22d. ADDRESS Sharptown, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7-10-66		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City, town or county) (State) Laurel, Del.			
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.					25a. REC'D BY REGISTRAR JUL 12 1966					
					25b. REGISTRAR'S SIGNATURE Charles Judge					

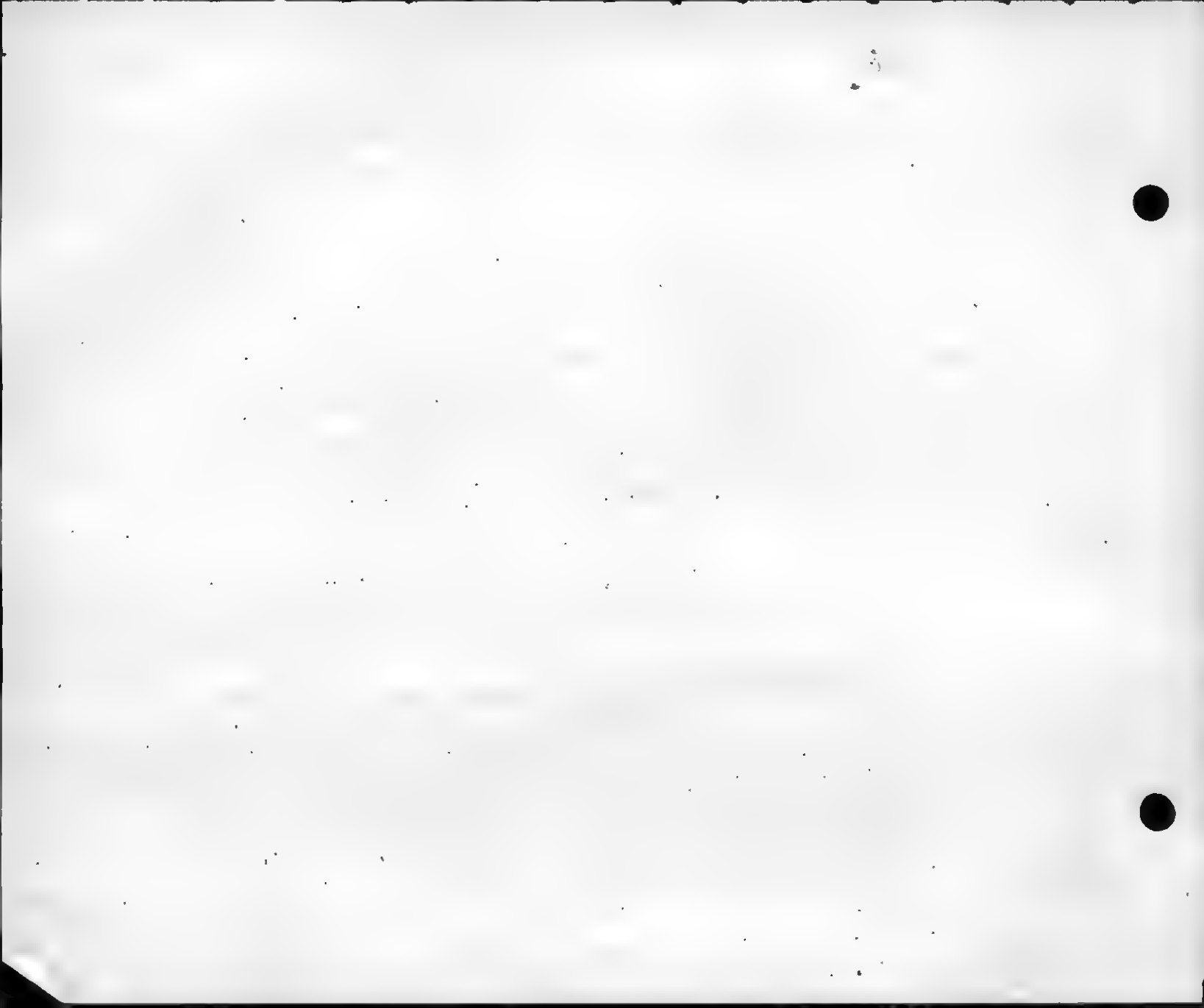


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>5 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>213 sixth Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William Cleveland Mariner</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAY 10, 1891</u> 9. AGE (in years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						4. DATE OF DEATH <u>July 7 1966</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OIL PRODUCTS</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Accomack County, VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEORGE S. MARINER</u> 14. MOTHER'S MAIDEN NAME <u>MALISSA EAST</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>212-10-8397</u> 17. INFORMANT <u>GEORGE L. MARINER, Pocomoke City, MD.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>ASCV Disease</u> DUE TO (c) <u>Symptomatic Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>14+</u> <u>2 Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1/20</u>, 19<u>58</u>, to <u>7/7</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>7/7</u>, 19<u>66</u>, and that death occurred at <u>4:10</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>John M. Bloxom III</u> 22c. PHYSICIAN'S NAME (Type) <u>J. M. BLOXOM III</u>						22b. DATE SIGNED 22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u> M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>7-9-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FIRST BAPTIST</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke City, Maryland</u>					
24. FUNERAL DIRECTOR <u>Robert H. Watson</u> 25a. REC'D BY REGISTRAR <u>Robert H. Watson</u> 25b. REGISTRAR'S SIGNATURE <u>Robert H. Watson</u>						25c. ADDRESS <u>Pocomoke City, MD.</u> 25d. DATE <u>JUL 12 1966</u>							



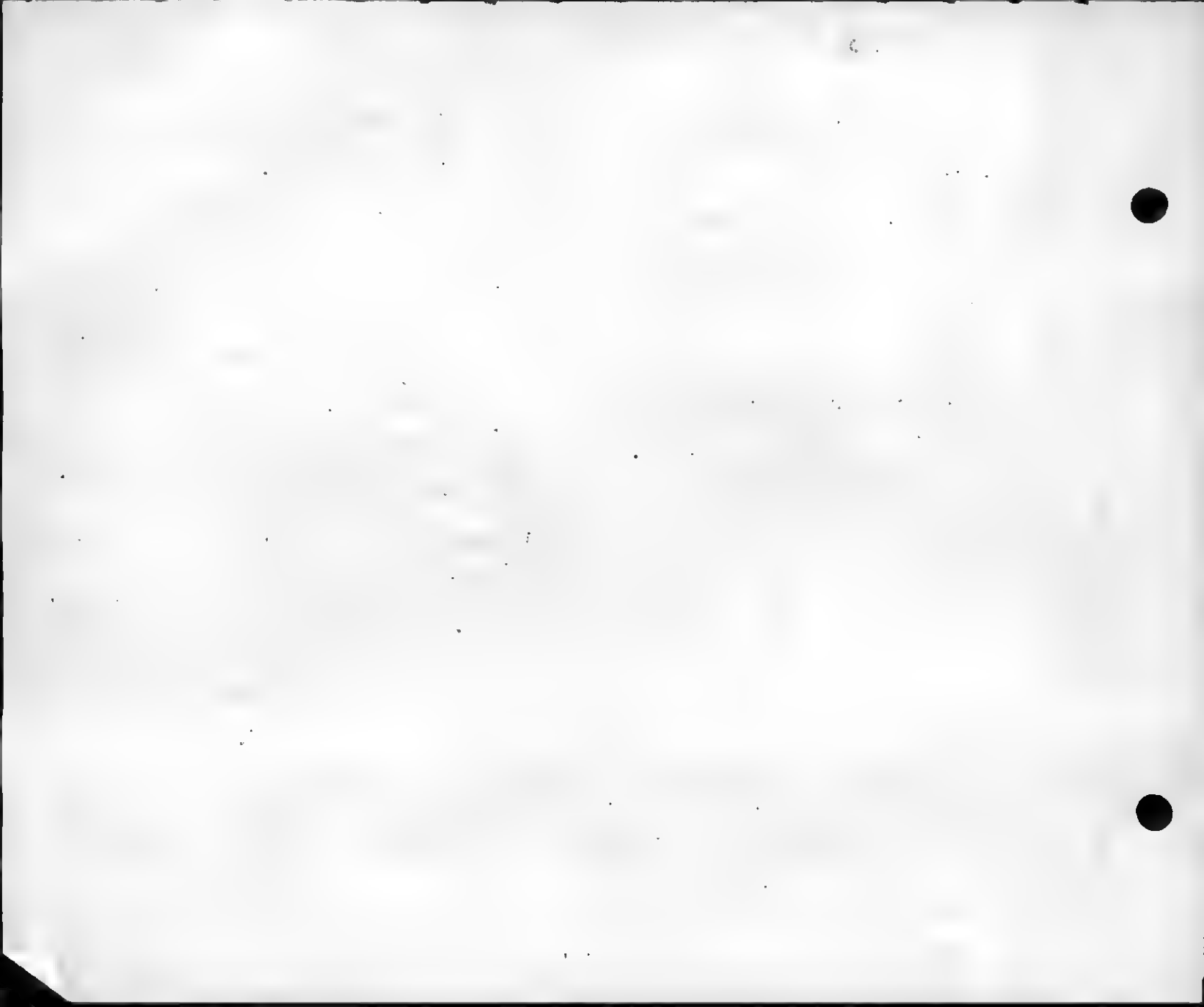
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VR A15 (4)
20M 1/65

W.P.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Route # 1 Box 306</u>				
3. NAME OF DECEASED (Type or print) <u>CARRIE E. Martin</u>					4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 9 1905</u>		9. AGE (In years last birthday) <u>60</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WORCESTER, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>CHARLES BRATTEN</u>					14. MOTHER'S MAIDEN NAME <u>SARA HOLLAND</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>215 16 3777</u>		17. INFORMANT <u>WILLIE MARTIN, Snow Hill, MD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Congestive failure</u> DUE TO (c) <u>Chronic Lung disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 wks</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> to <u>July</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>July 15</u> , 19 <u>66</u> and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>David R. Ratt</u>					22b. DATE SIGNED <u>July 15 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>DAVID RATT MD.</u>					22d. ADDRESS <u>Snow Hill, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7/19/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. WESLEY</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, MD.</u>		
24. FUNERAL DIRECTOR <u>Dennis Funeral Home, Snow Hill, MD.</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

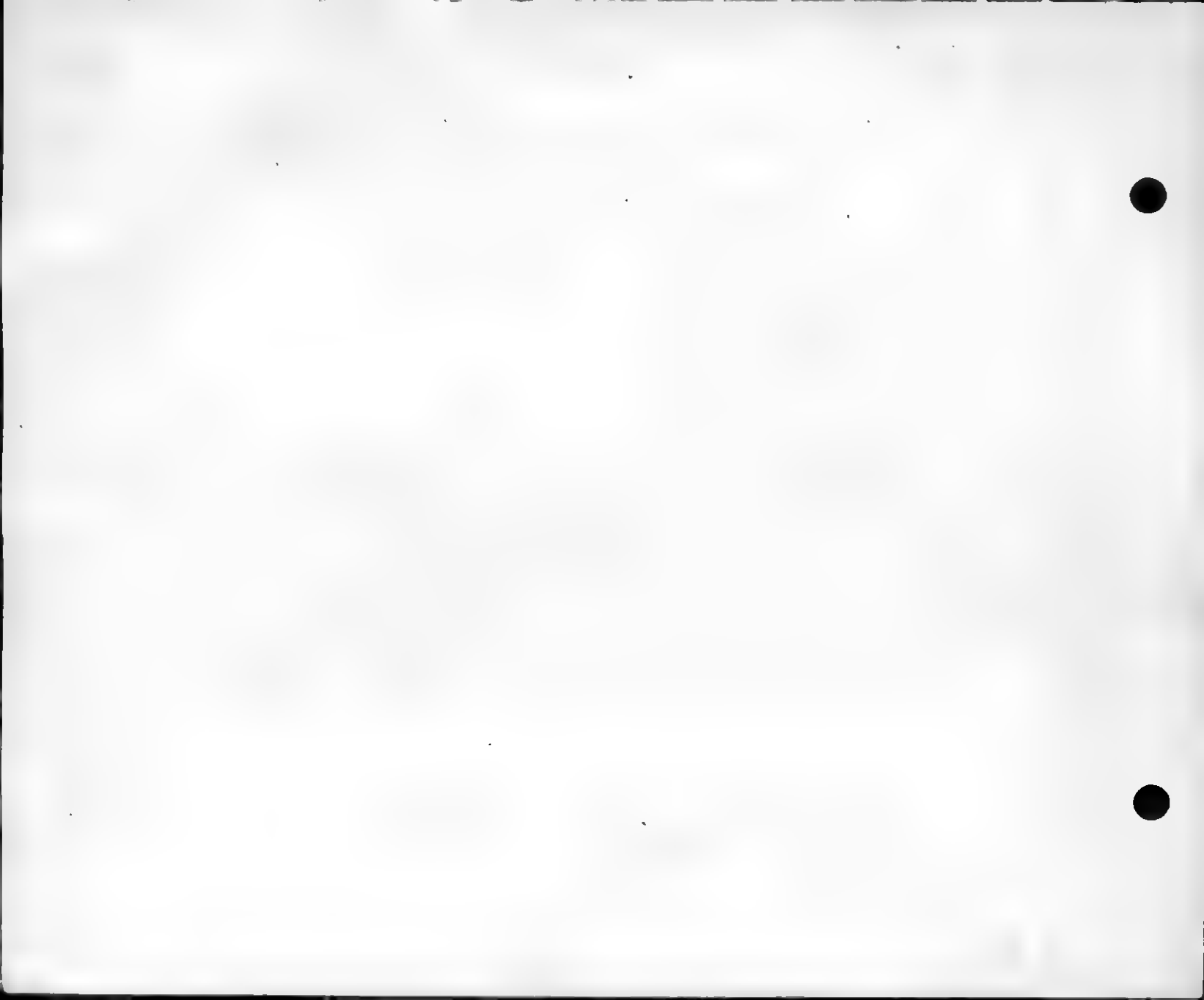
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Jersey Road</u>	
3. NAME OF DECEASED (Type or print) <u>Benny, Jr. MASON</u>		4. DATE OF DEATH <u>JULY 31 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30, 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico-MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benny MASON</u>		14. MOTHER'S MAIDEN NAME <u>Florence Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Benny Mason</u>		Address <u>Jersey Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>7625</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>26 hr. 37 min</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 1966, to <u>7/31</u> , 1966, that (I) (we) last saw the deceased alive on <u>7/31</u> , 1966, and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>D. S. Anderson</u>		22b. DATE SIGNED <u>7/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DANIEL ANDERSON</u>		22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury Maryland</u>
24. FUNERAL DIRECTOR <u>Arthur E. Stewart</u>		25a. REC'D BY REGISTRAR <u>Salisbury Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 8 1966</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and informally event within 72 hours after death.

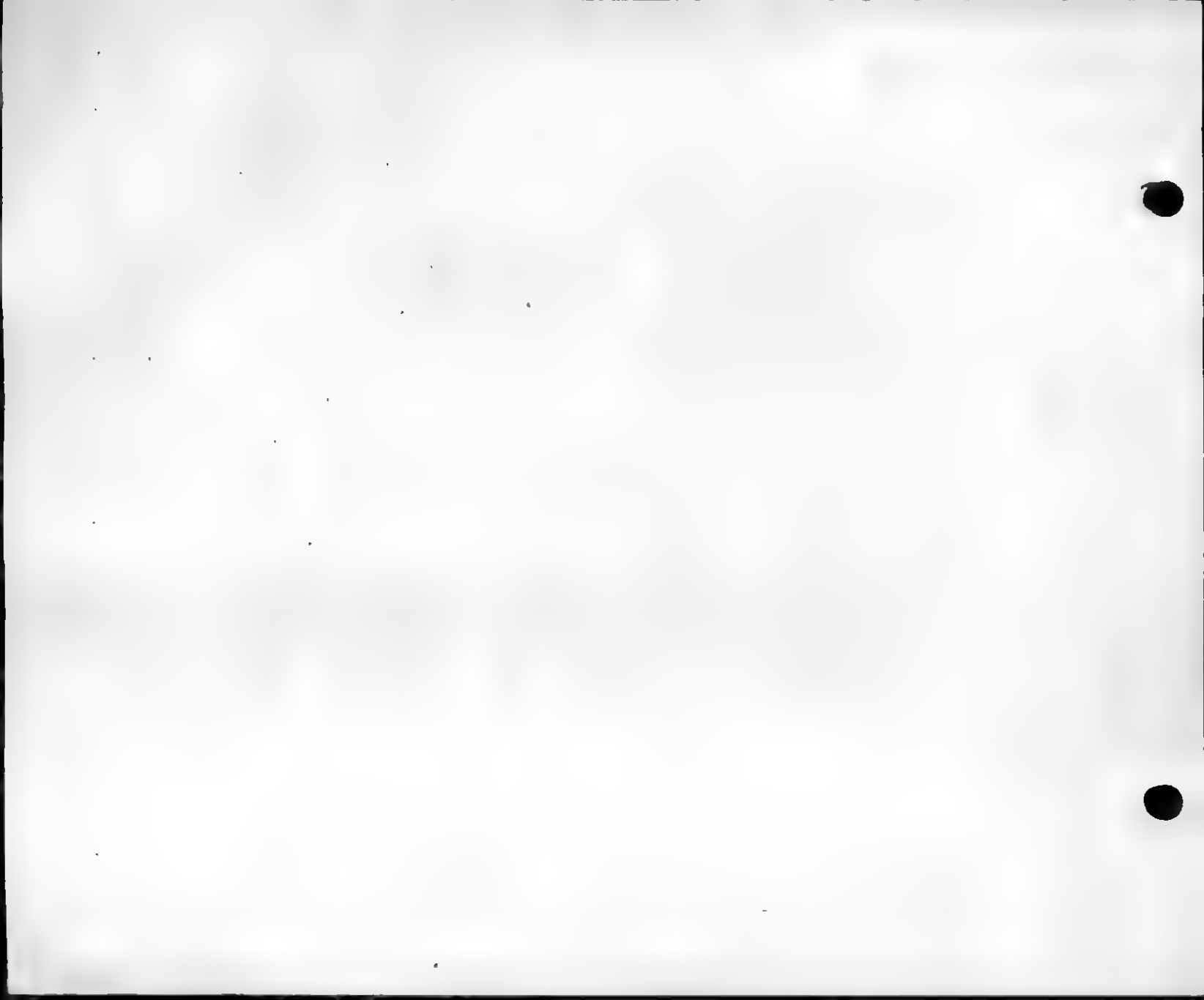
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10711

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS 11th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RALPH STEWART MATHIAS, SR.		4. DATE OF DEATH Month Day Year July 9 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1903
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Meat Products	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stewart Mathias		14. MOTHER'S MAIDEN NAME Emma Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-6616	
17. INFORMANT Mrs Iola Hill Mathias, Maryland		Address Pocomoke City,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Due to (b) Pulmonary embolism - Reticular pneumonia (c) Due to		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident	
20c. TIME OF INJURY Month, Day, Year 3:30 a.m. 6-21-1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Pocomoke Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert H. Watson		22. DATE SIGNED 7-11-66	
EXAMINER'S NAME (Type) Robert H. Watson		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-1966	
23c. NAME OF CEMETERY OR CREMATOR Fairview Lawn		23d. LOCATION (City, town or county) (State) Onancock, Virginia	
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Pocomoke City, Md.	
25a. REC'D BY REGISTRAR JUL 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

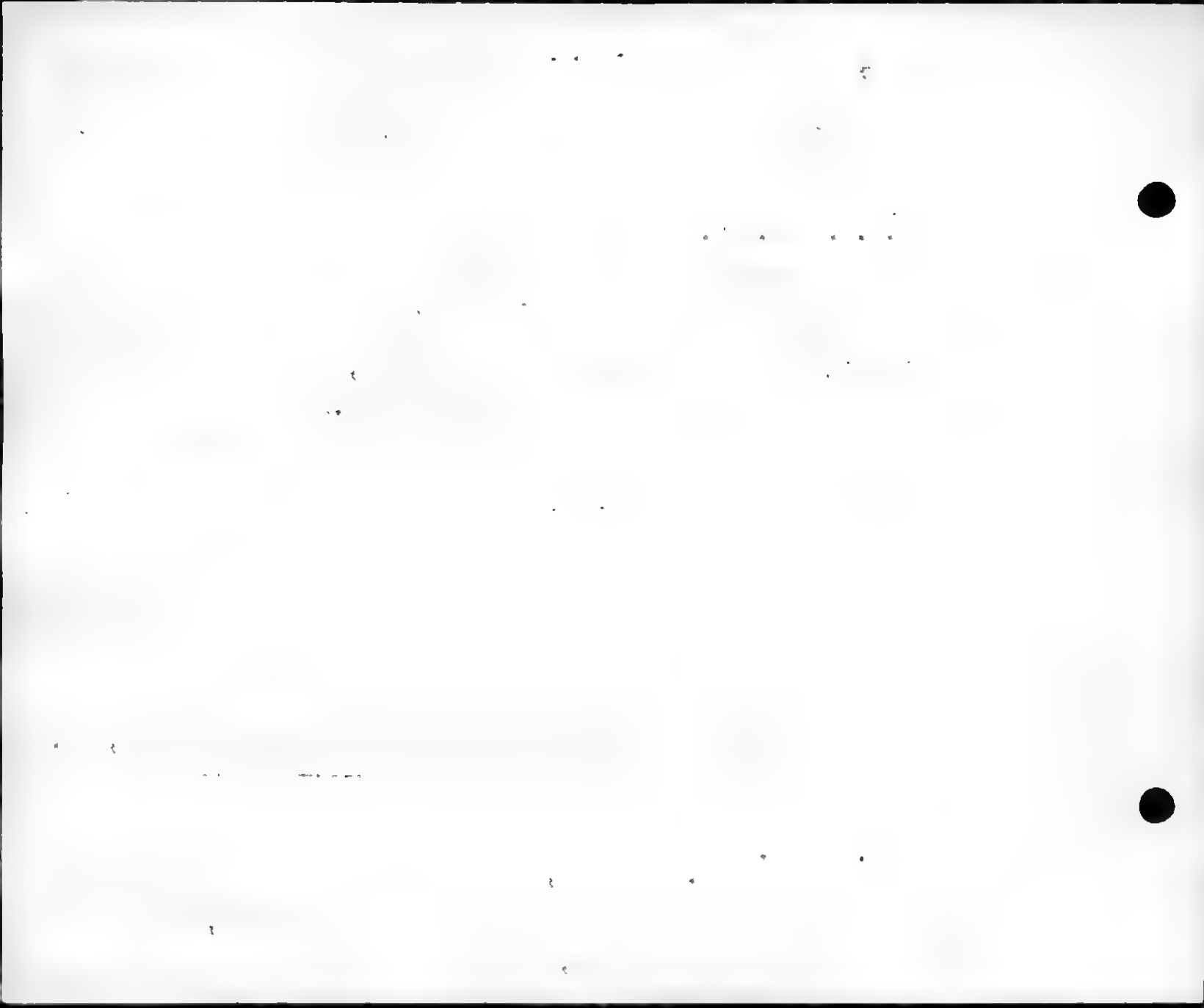
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10712

10705

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Schumaker Pond D.O.A. Pen. Gen. Hospital				d. STREET ADDRESS 213 A Davis Street			
3 NAME OF DECEASED (Type or print) First Middle Last ROBERT LEE MATTHEWS				4 DATE OF DEATH Month Day Year JULY 14 1966			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 5/1956	9 AGE (n years last birthday) 10	10 UNDER 1 YEAR Months Days Hours Min. 02 09		11 UNDER 24 HRS. Hours Min. 02 09
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unk				14. MOTHER'S MAIDEN NAME Virginia D. Moore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Mother (Same as #2 and #14)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Drowning in Pond					
20c. TIME OF INJURY Month, Day, Year 3:45 (p.m.) 7/14/66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Schumaker Pond		20f. (City or town) (County) (State) Wicomico County, Md.		
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. Earl L. Royer EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. DATE SIGNED July 16, 1966							
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF July 16/1966		23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		23d. LOCATION (City or town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR JUL 18 1966		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

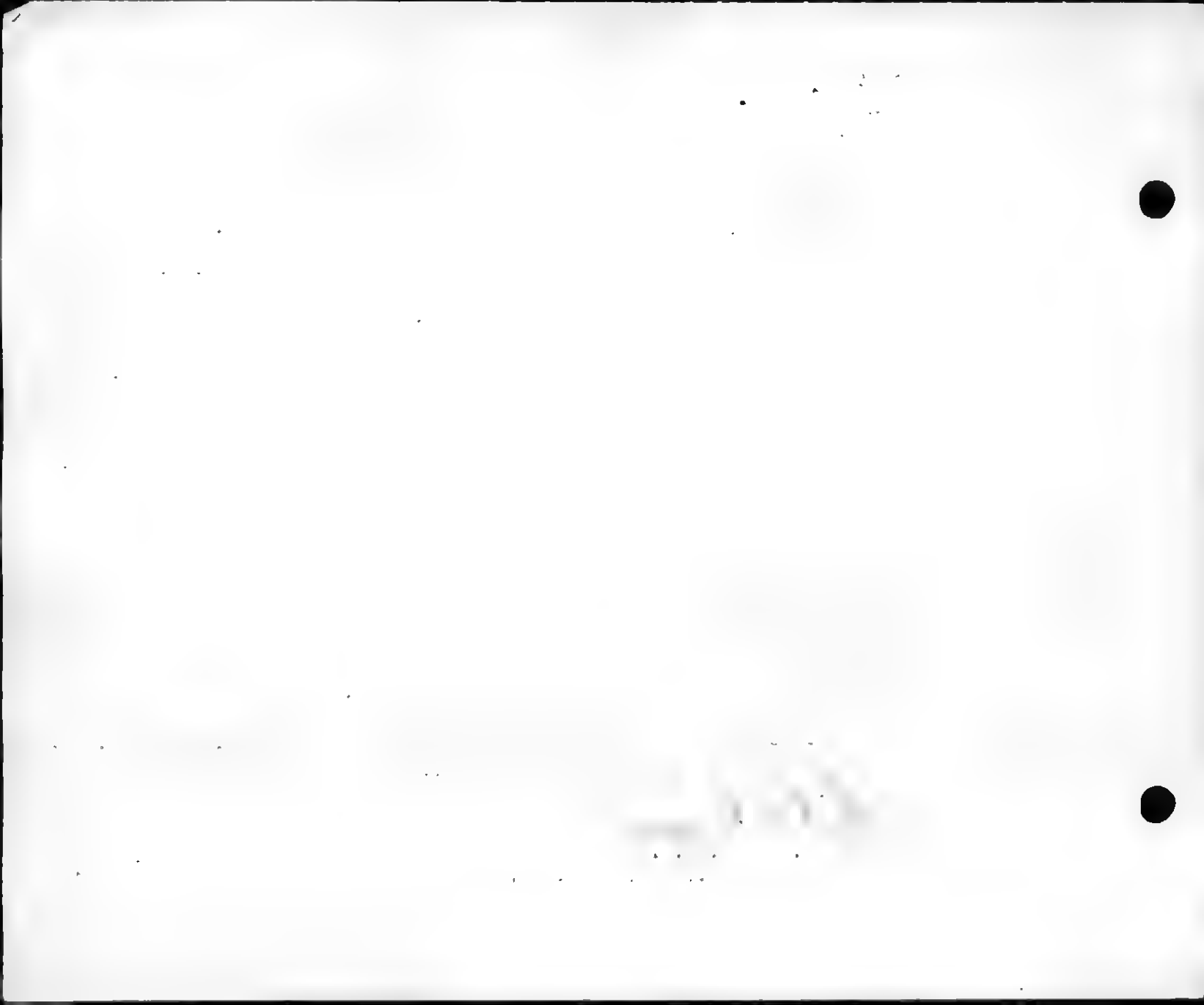
10706

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS 726 Delaware Ave.	
3 NAME OF DECEASED (Type or print) First JANET Middle MEMSON Last MEMSON		4 DATE OF DEATH Month 7 Day 17 Year 66	
5 SEX Female	6 COLOR OR RACE AA	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April, 1966
9 AGE (In years last birthday) 3		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Janet Burris	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Isaac Menson	
14 MOTHER'S MAIDEN NAME Janet Burris		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17 INFORMANT Isaac Menson & El. Royer, Salis Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration of Vomitus (c) (Sudden death in infancy)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTR. BUT. NO <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Found not breathing in crib.	
20c TIME OF INJURY Month, Day, Year 6 7-17-66	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home	20f (City or town) (County) (State) Salisbury, Wicomico, Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED July 21, 1966	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/21/1966	23c NAME OF CEMETERY OR CREMATORY Green Acres	23d LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Md.
24 FUNERAL DIRECTOR Walter F. Stewart		25a REC'D BY REGISTRAR DATE JUL 27 1966	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

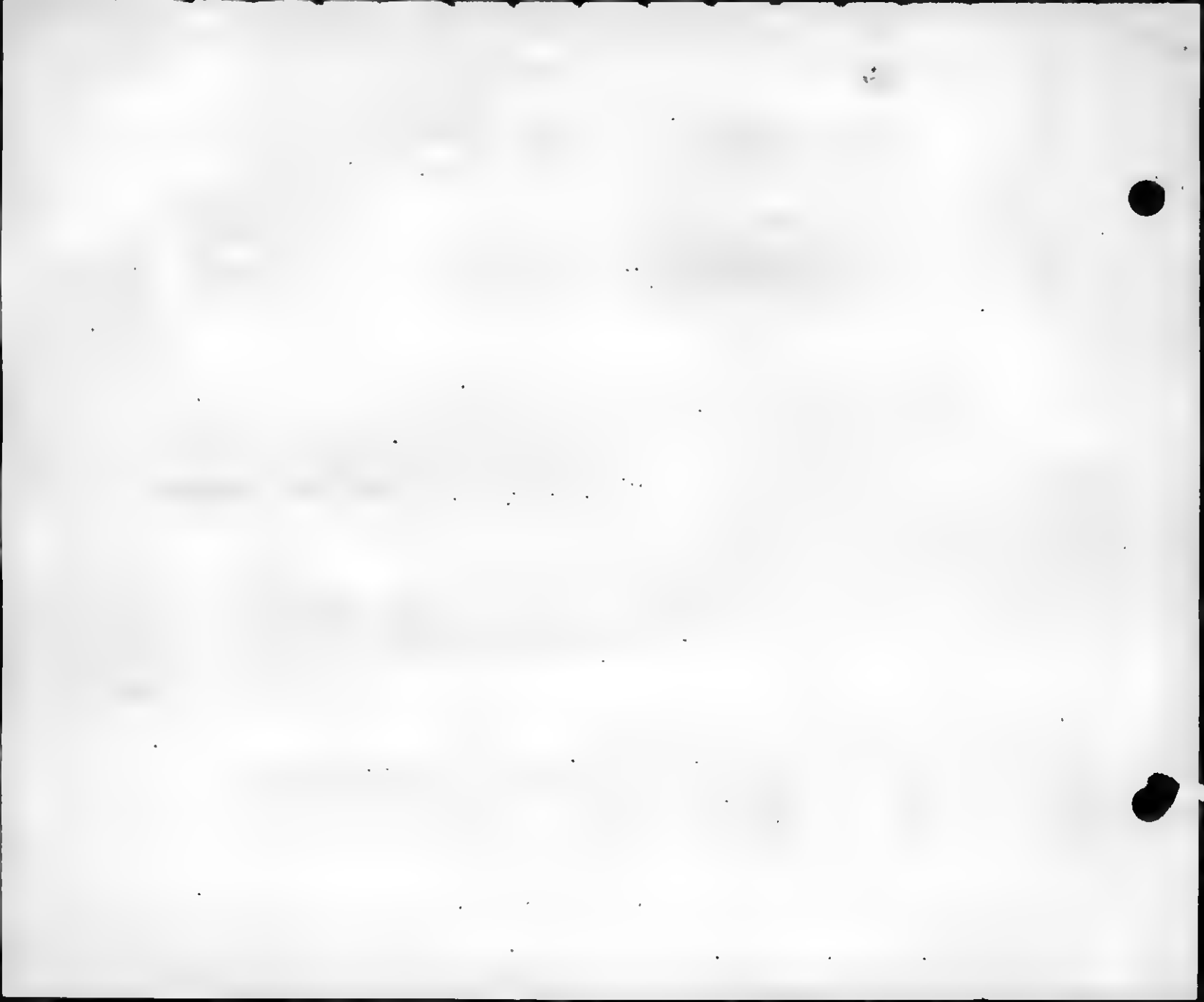
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

W.P.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DELMAR d. STREET ADDRESS ELIZABETH	
3. NAME OF DECEASED (Type or print) ANNA ELIZABETH Mills		4. DATE OF DEATH July 27 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ebenezer White		14. MOTHER'S MAIDEN NAME ROSA A. BORDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT EUGENE MILLS - DELMAR-MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Damaged left leg (amputation)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/16 , 19 66 , to 7/27 , 19 66 that (I) (we) last saw the deceased alive on 7/27 , 19 66 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Marrel		22b. DATE SIGNED 7-27-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-30-66	23c. NAME OF CEMETERY OR CREMATORY ST STEPHENS	23d. LOCATION (City, town or county) (State) DELMAR DEL
24. FUNERAL DIRECTOR Charles H. Marrel		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Delmar, Del		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE JUL 29 1966			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word pending in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

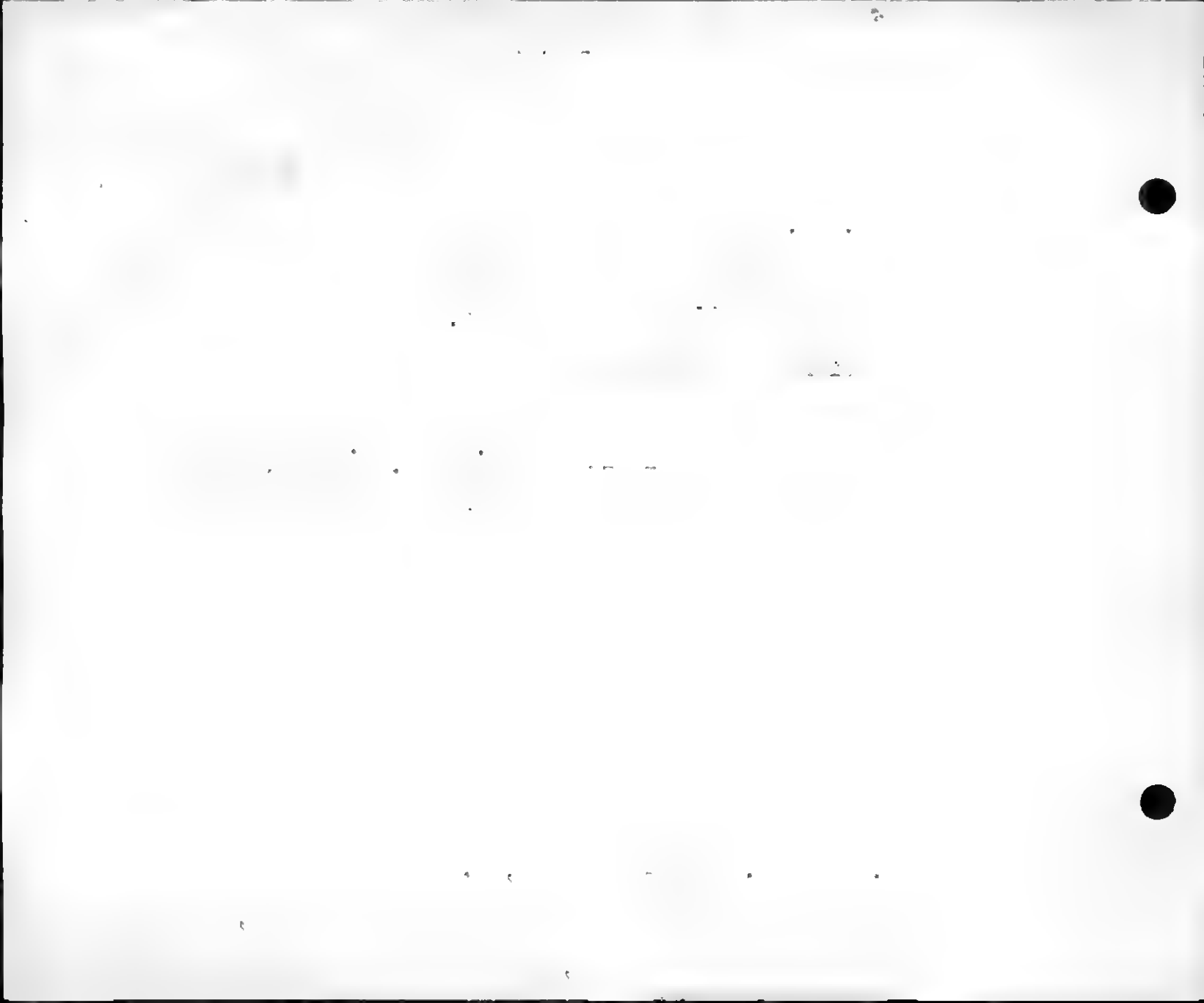
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10715

10708

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c LENGTH OF STAY n 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron KRUX Box#457		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen.Gen.Hospital				d STREET ADDRESS Walnut Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last FRANKLIN WILSON MILLS				4 DATE OF DEATH Month Day Year JULY 17th 19 66			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept.19/1918	
9 AGE (in years last birthday) 47 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b KIND OF BUSINESS OR INDUSTRY Electrical		11 BIRTHPLACE (State or foreign country) Delaware	
12 CITIZEN OF WHAT COUNTRY? U S A				13 FATHER'S NAME Talbot Mills			
14 MOTHER'S MAIDEN NAME Ola Kennerly				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16 SOCIAL SECURITY NO 218-07-5439				17 MANT Mrs. Madora H. Mills (Wife) Box#457 Walnut St. Hebron, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Decomposition Left Coronary Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)					
20c TIME OF INJURY Month Day Year Hour am pm 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. Philip A. Insley-Salisbury, Md.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-18-66	
EXAMINER'S NAME (Typed)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a B. RIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF July 20/66		23c NAME OF CEMETERY OR CREMATORY Hebron Cemetery		23d LOCATION (City or Town) (County) (State) Hebron, Maryland	
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				25a REC'D BY REG. STRAR DATE JUL 22 1966		25b REGISTRAR'S SIGNATURE Charles Judge	

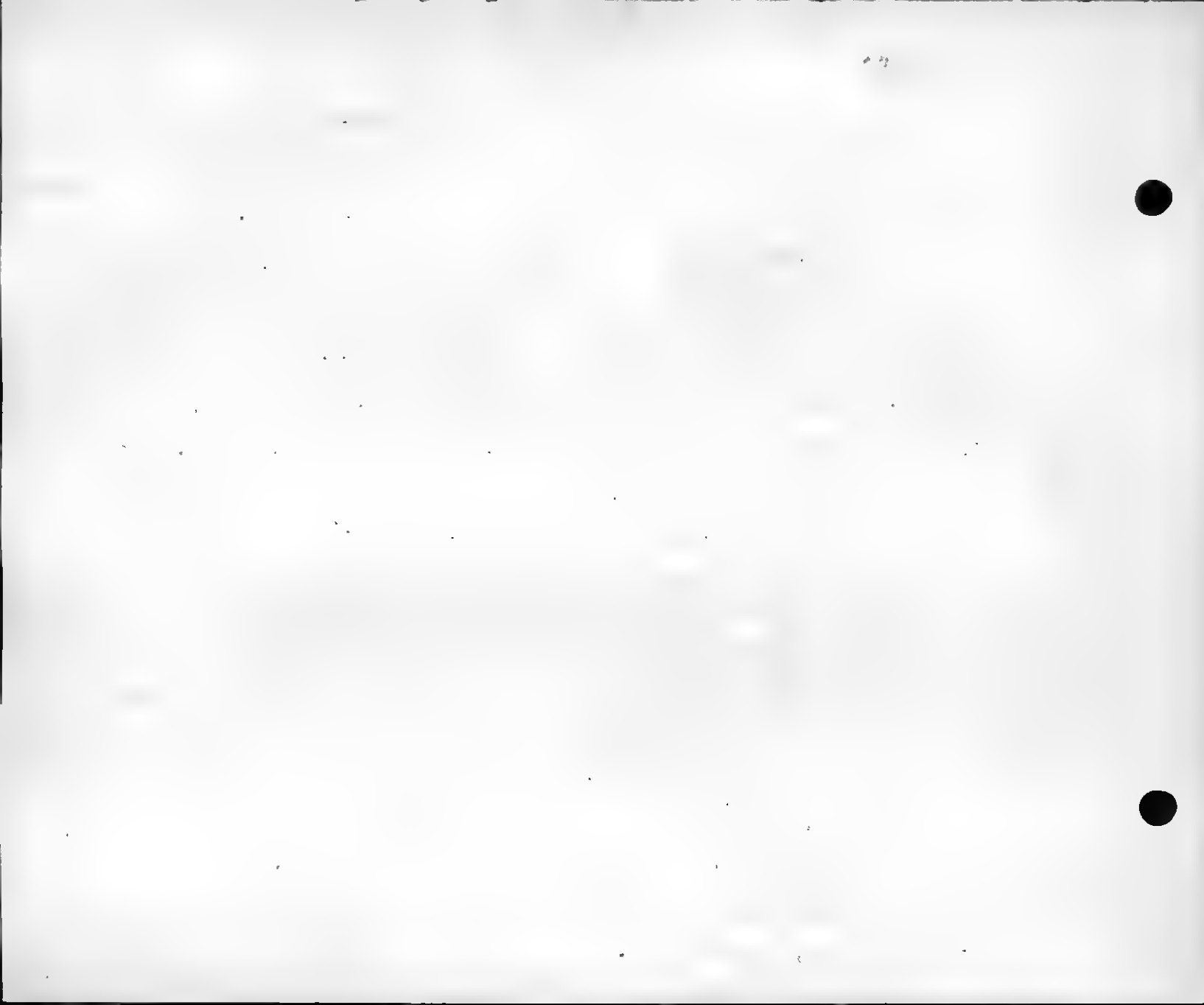


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

209

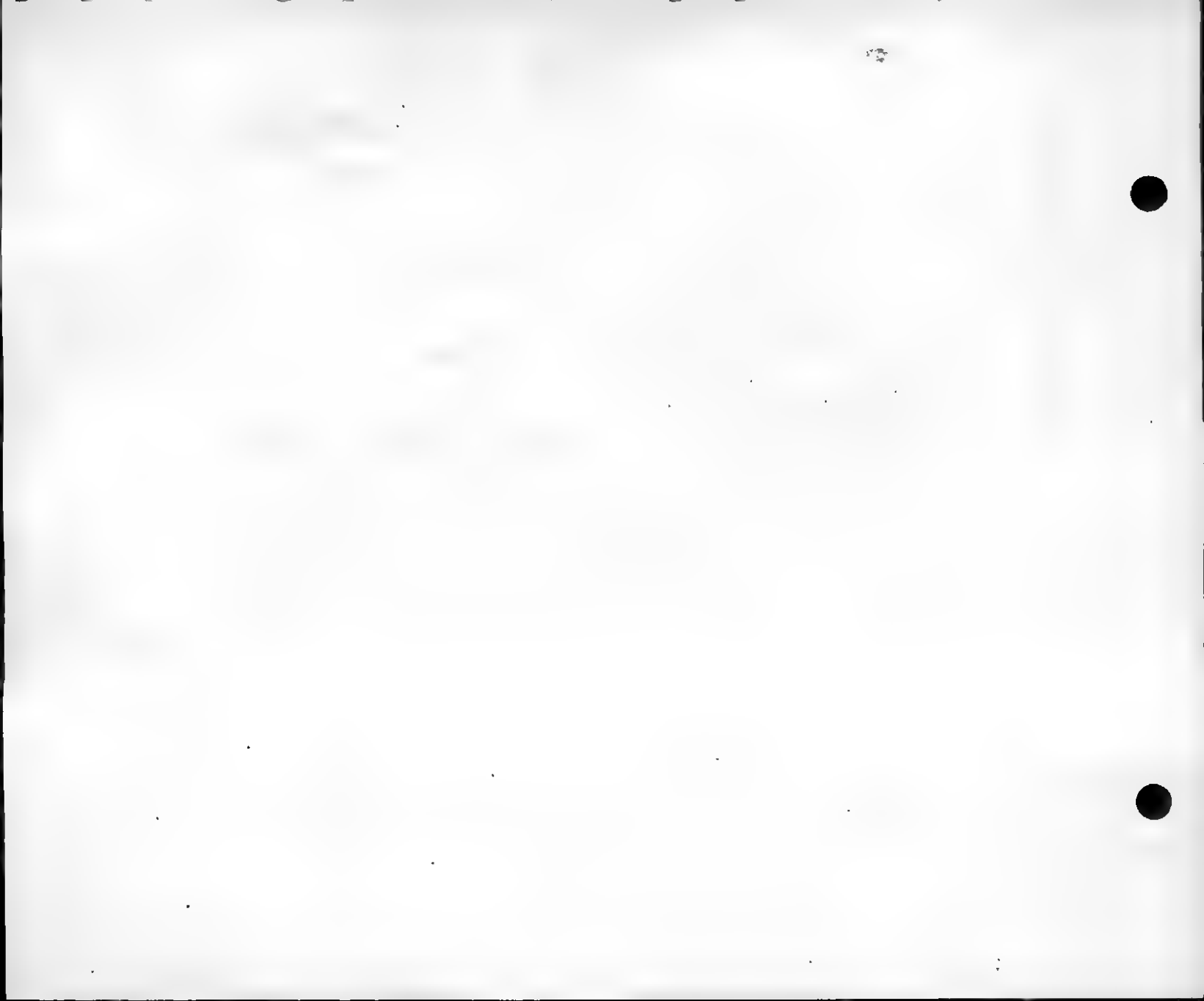
<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN ID <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> d. STREET ADDRESS <u>214 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>James Lee Mister</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 3, 1940</u> 9. AGE (In years last birthday) <u>26</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>						4. DATE OF DEATH <u>July 24</u> 19 <u>66</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Crisfield, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>James E. Mister</u> 14. MOTHER'S MAIDEN NAME <u>Floris Landon</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Floris Mister, Same as 2. 1bcd</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Diabetic nephropathy + Cardiopathy</u> } DUE TO (c) <u>Uremia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>											
21. I certify that (I) (this hospital) attended the deceased from <u>7/19, 1966</u> to <u>7/24, 1966</u> that (I) (we) last saw the deceased alive on <u>7/24, 1966</u> and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>William D. Gray, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>William D. Gray</u> 22b. DATE SIGNED <u> </u> 22d. ADDRESS <u>Salisbury, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7/27/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u> 23d. LOCATION (City, town or county) <u>Crisfield, Md.</u> (State) <u> </u>											
24. FUNERAL DIRECTOR <u>Bradshaw & Sons, Crisfield, Md.</u> ADDRESS <u> </u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>AUG 3 1966</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN ID <u>10717</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wenona</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Thelma</u>		First		Middle		Last <u>Mister</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1966</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>66</u> yrs.		9. AGE (in years last birthday) <u>66</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co; Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Daniels</u>		14. MOTHER'S MAIDEN NAME <u>Alice Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mervin Mister, Deal Island Md.</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1966</u> , to <u>July 17, 1966</u> , that (I) was last saw the deceased alive on <u>July 17, 1966</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.		22b. DATE SIGNED <u>7/17/66</u>	
22a. SIGNATURE <u>Thomas C. Hill Jr.</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>THOMAS C HILL, Jr.</u>		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>7/19/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Deal Island Md.</u>		24a. REC'D BY REGISTRAR <u>James Herman Precourt</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 20 1966</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

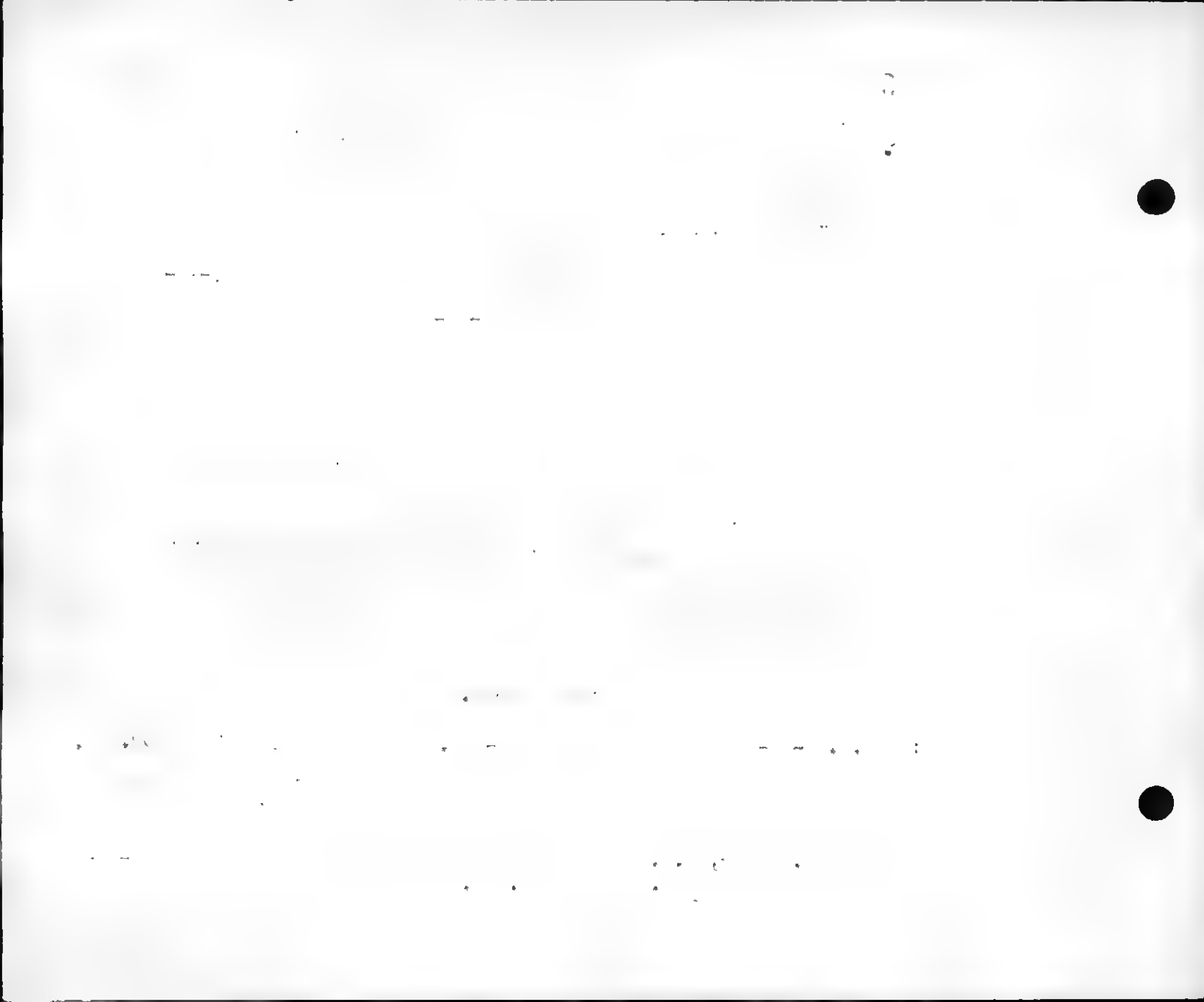
10711

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Delaware b. COUNTY Delaware ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dagsboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) George Allen Murray		4 DATE OF DEATH 7-13-66	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-26-48
9 AGE (in years last birthday) 17 yrs		F UNDER 1 YEAR 19 Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) DELAWARE		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME EARIS MURRAY		14 MOTHER'S MAIDEN NAME JEANITA MURRAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO ZZ-32-317	
17 INFORMANT EARIS MURRAY, Dagsboro Del.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY - IMMEDIATE CAUSE (a) Fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multiple fractures of pelvis and extremities (c) None DUE TO			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Found dead on road.	
20c. TIME OF INJURY Month, Day, Year 12:30 P.M. 7-13-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work Road - Rt. 610	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Whayleysville Wor. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22 DATE SIGNED 7-16-66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL SERIAL		23b. DATE THEREOF 7-19-66	
23c. NAME OF CEMETERY OR CREMATORY ST. GEORGES		23d. LOCATION (City or Town) (County) (State) CLARKSVILLE SUSSEX DEL.	
24. FUNERAL DIRECTOR A. Douglas Nelson, Frankford, Del.		25a. REC'D BY REGISTRAR JUL 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

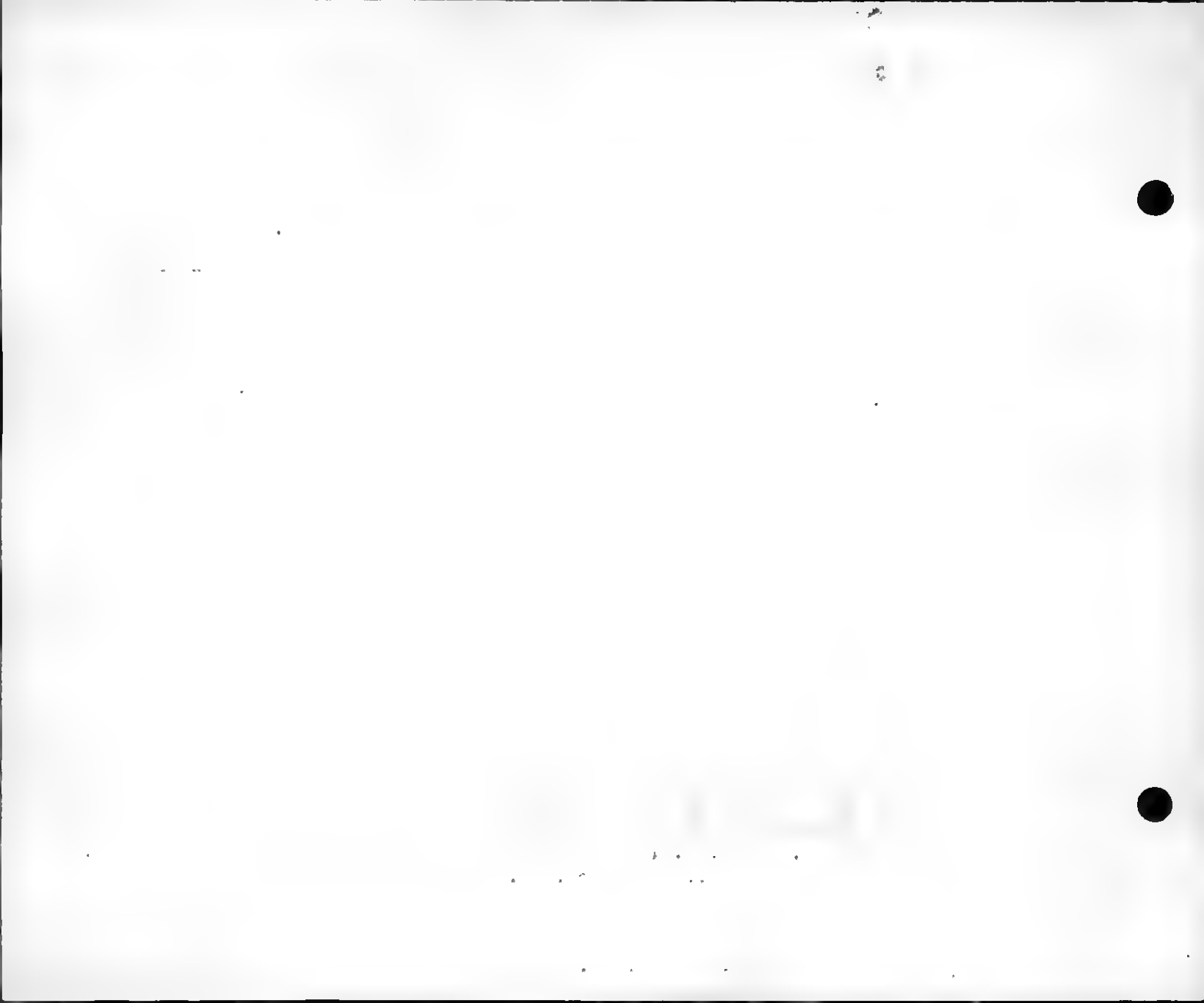
FOR STATE HEALTH DEPT.

10719

10712

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Keyser Pt. Road	
3 NAME OF DECEASED (Type or print) First GEORGE Middle WILKES Last MURRAY		4 DATE OF DEATH Month 7 Day 28 Year 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JULY 2, 1908
9 AGE (In years last birthday) 58 yrs		10 IF UNDER 1 YEAR Months 5 Days 5 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY ICE PLANT	
11 BIRTHPLACE (State or foreign country) WILKES BARRE		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JOSEPH A. MURRAY		14 MOTHER'S MAIDEN NAME ELIZABETH DAVIS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WORLD WAR II		16 SOCIAL SECURITY NO. 216-07-4140	
17 INFORMANT Mrs. GEORGE W. MURRAY		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage mid brain DUE TO SOX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		INTERVAL BETWEEN ONSET AND DEATH Hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		22. DATE SIGNED July 29, 1966 Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/31/66	23c. NAME OF CEMETERY OR CREMATORY BARRETT'S CHAPEL	23d. LOCATION (City or town) (County) (State) FREDERICK DEL.
24. FUNERAL DIRECTOR Burbage Funeral Home, Berlin, Md.		25a. REC'D BY REGISTRAR AUG 2 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

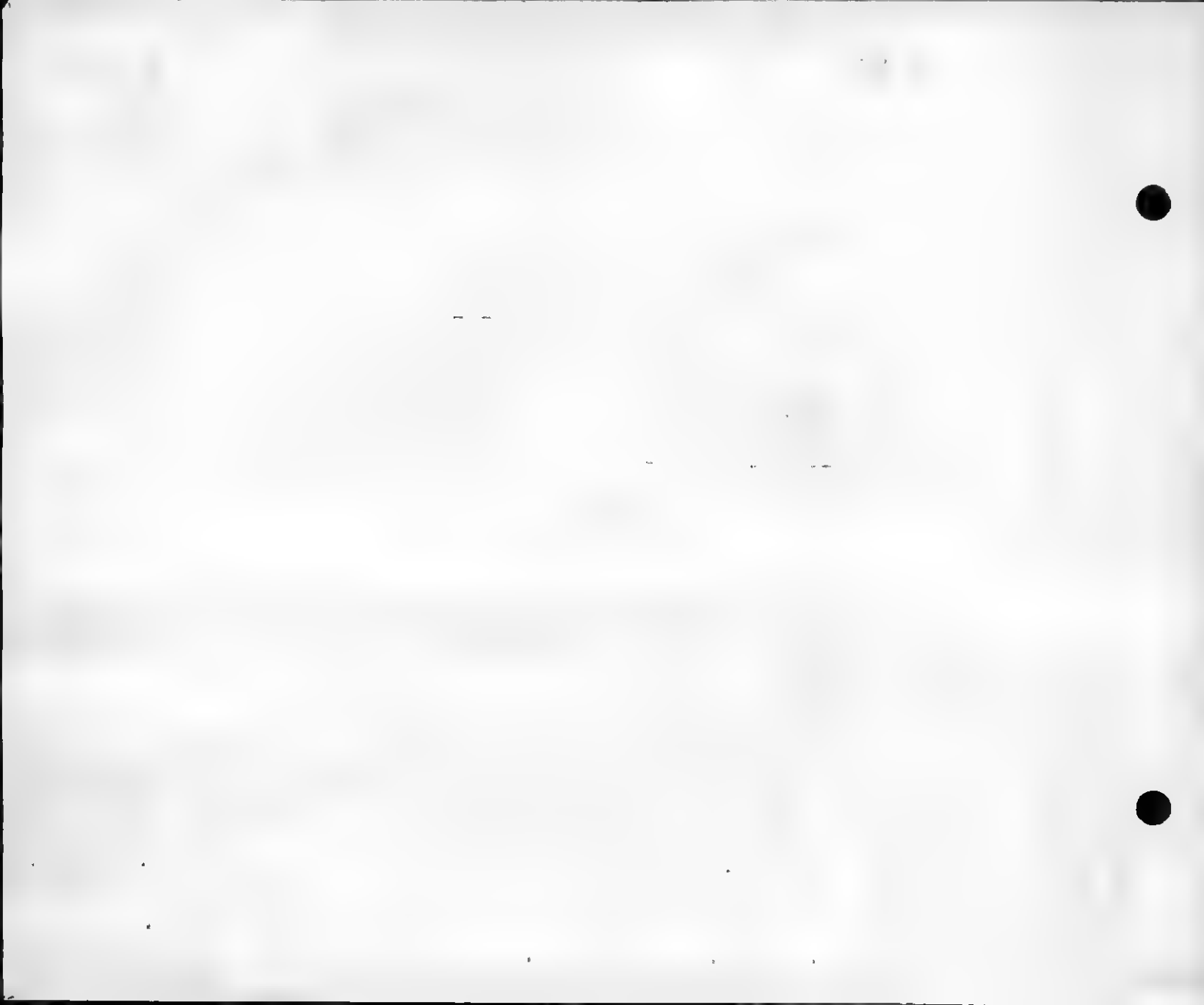
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10720

CERTIFICATE OF DEATH

10713

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY in 1b 855 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg, Rt. 1 d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ETHEL Middle TRENE Last NIBLETT		4. DATE OF DEATH Month July Day 29 Year 1966				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1893	9. AGE (in years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Isaac Mitchell				14. MOTHER'S MAIDEN NAME Cynthia Farmer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 223-32-1596		17. INFORMANT Deer's Head State Hospital Records Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic cystitis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the cervix 7/78						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/26/64 , 19 to 7/29 , 19 66 , that (I) (we) last saw the deceased alive on 7/29 , 19 66 , and that death occurred at 3:34 PM , from causes and on the date stated above.						
22a. SIGNATURE Charles H. Winnacott		22b. DATE SIGNED 7/29/66		22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-31-66		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gds		23d. LOCATION (City or Town) (County) (State) Salisbury, Md.
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.				25a. REC'D BY REGISTRAR DATE AUG 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge



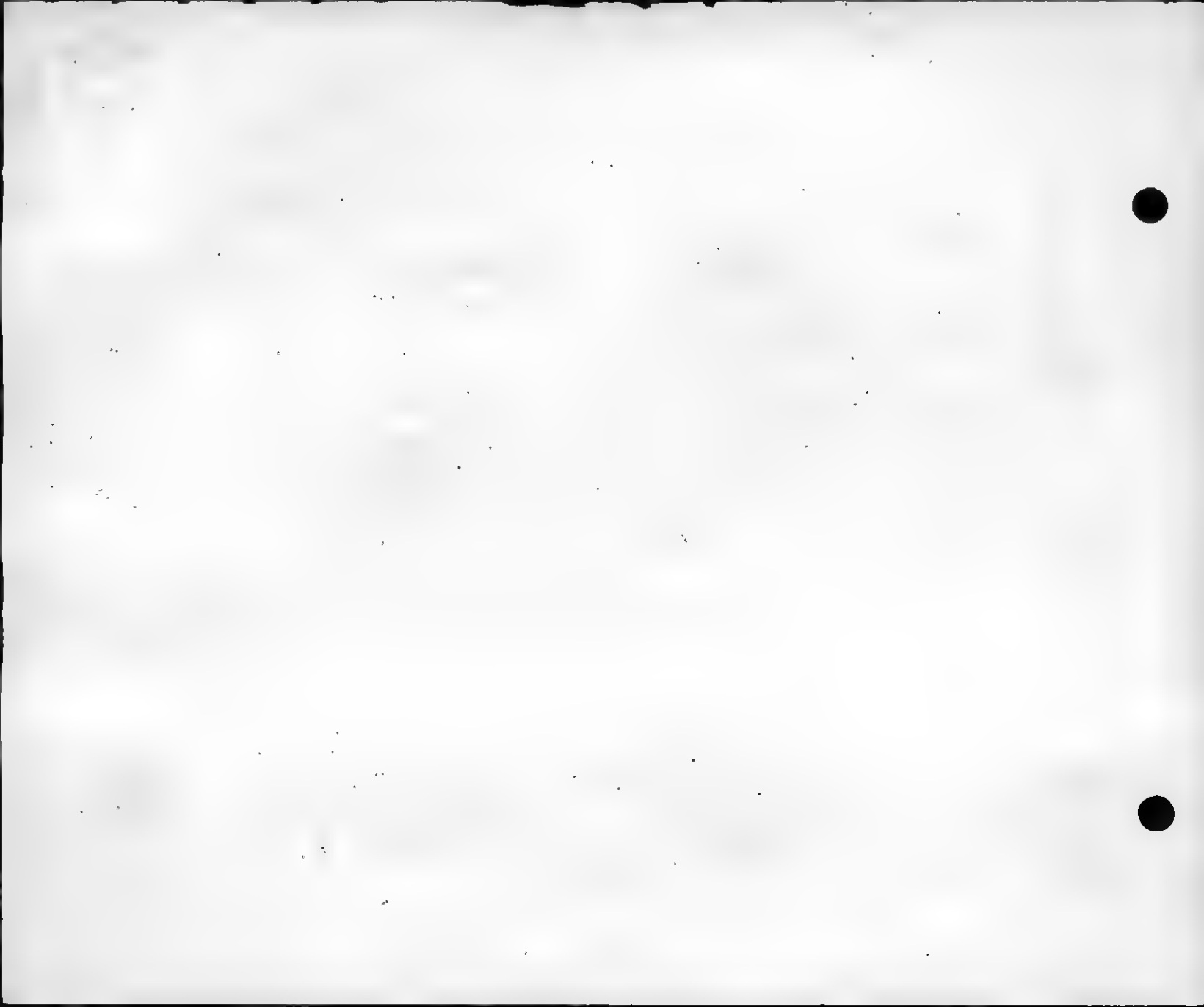
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10721 CERTIFICATE OF DEATH 10714

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
c. LENGTH OF STAY IN 1b <u>1 month</u>		d. STREET ADDRESS <u>1408 Philadelphia Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VIRGINIA</u> Middle <u>B.</u> Last <u>Payne</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years, last birthday) <u>86</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver A. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harriette E. Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Harriette Smith, 1408 Philadelphia Rd.</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (2)</u> 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/7/66</u> , to <u>7/6/66</u> , that (I) (we) last saw the deceased alive on <u>7/6/66</u> , 19 <u>66</u> , and that death occurred at <u>6:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>July 6, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. J. Burton M.D.</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 9, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Joppa Harford Co., Md.</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



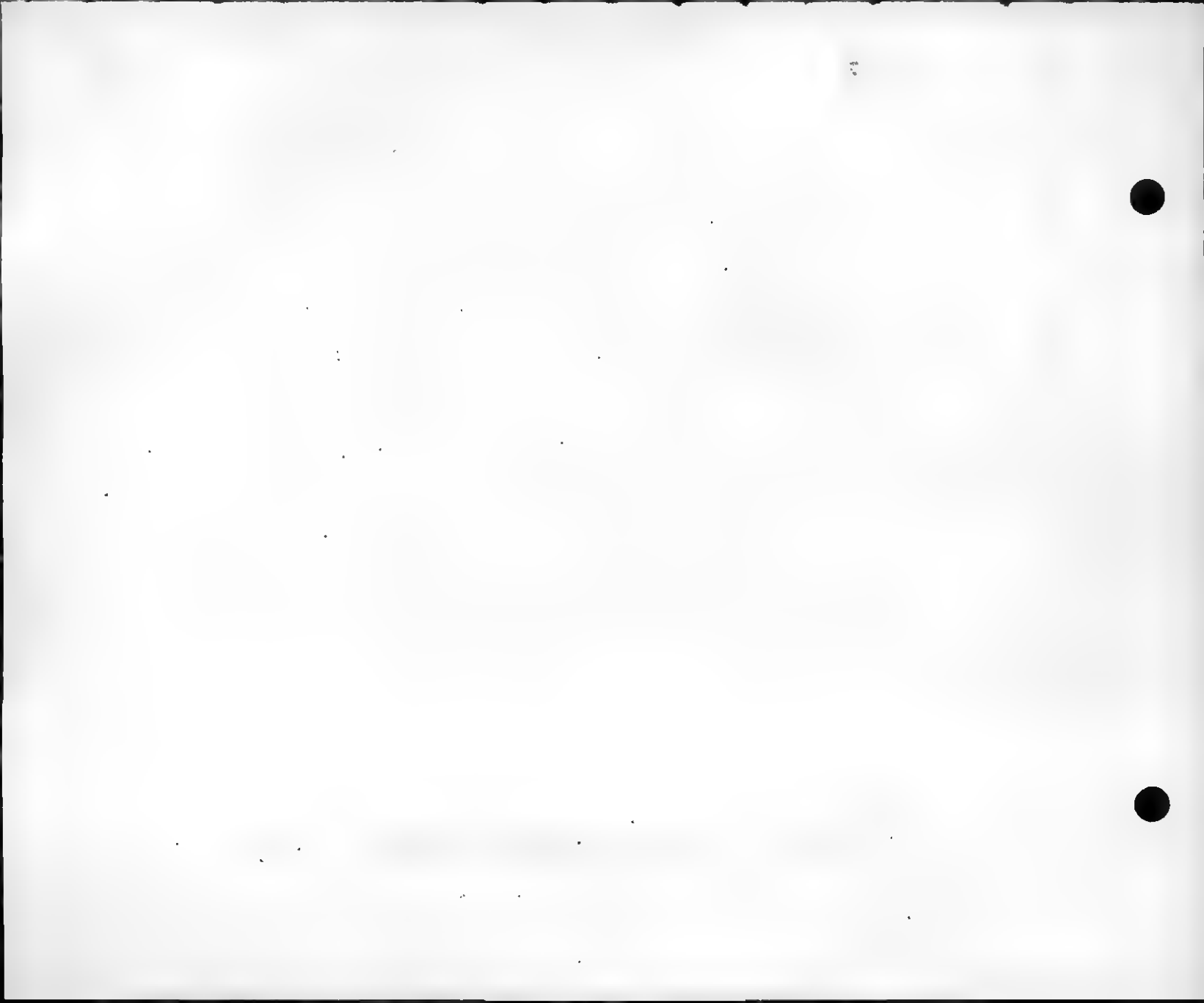
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

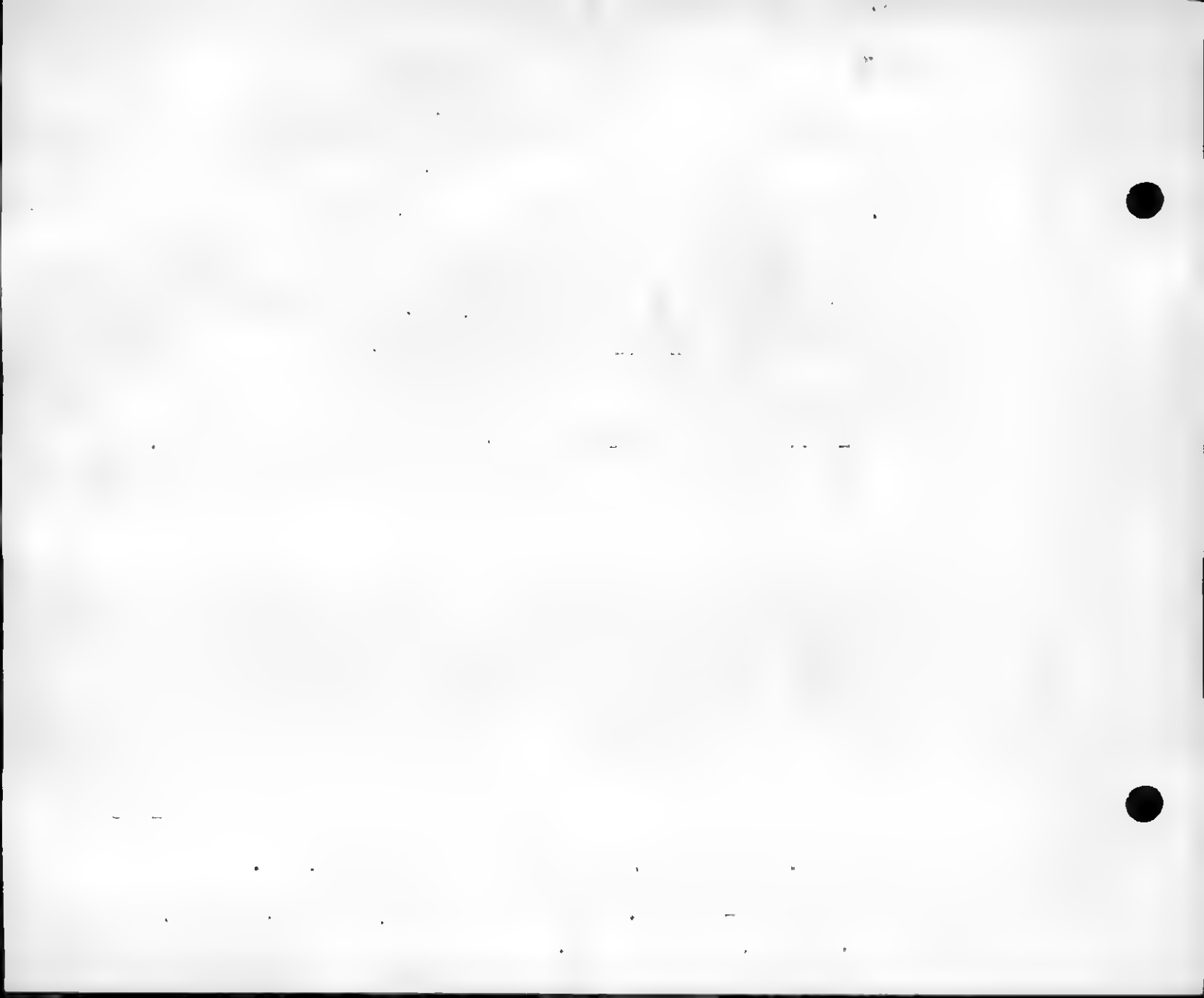
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10722					10715						
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>6 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY - RT. #5</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>HIGH BANKS</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>Edward</u> Last <u>PERRY</u>			4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1966</u>								
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 10, 1898</u>		9. AGE (in years last birthday) <u>68</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>RET. PHOTOGRAPHER COMMERCIAL</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>ROLAND PERRY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE HELVIN</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-10-8567</u>		17. INFORMANT <u>MRS. J.E. PERRY</u>			Address <u>SEE-2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonitis</u> DUE TO (b) <u>chronic obstructive pulmonary disease</u> DUE TO (c) <u>URA</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> , 19 <u>66</u> , to <u>7-27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-27</u> , 19 <u>66</u> , and that death occurred at <u>7:10</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>John G. Bulkeley</u> M.D.									22b. DATE SIGNED <u>7-27-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN G. BULKELEY</u>									22d. ADDRESS <u>MEDICAL CENTER - SALISBURY, MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/24/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMET.</u>			23d. LOCATION (City, town or county) (State) <u>SALISBURY, MD.</u>				
24. FUNERAL DIRECTOR <u>Edgar C. Hips</u>				ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 4-64

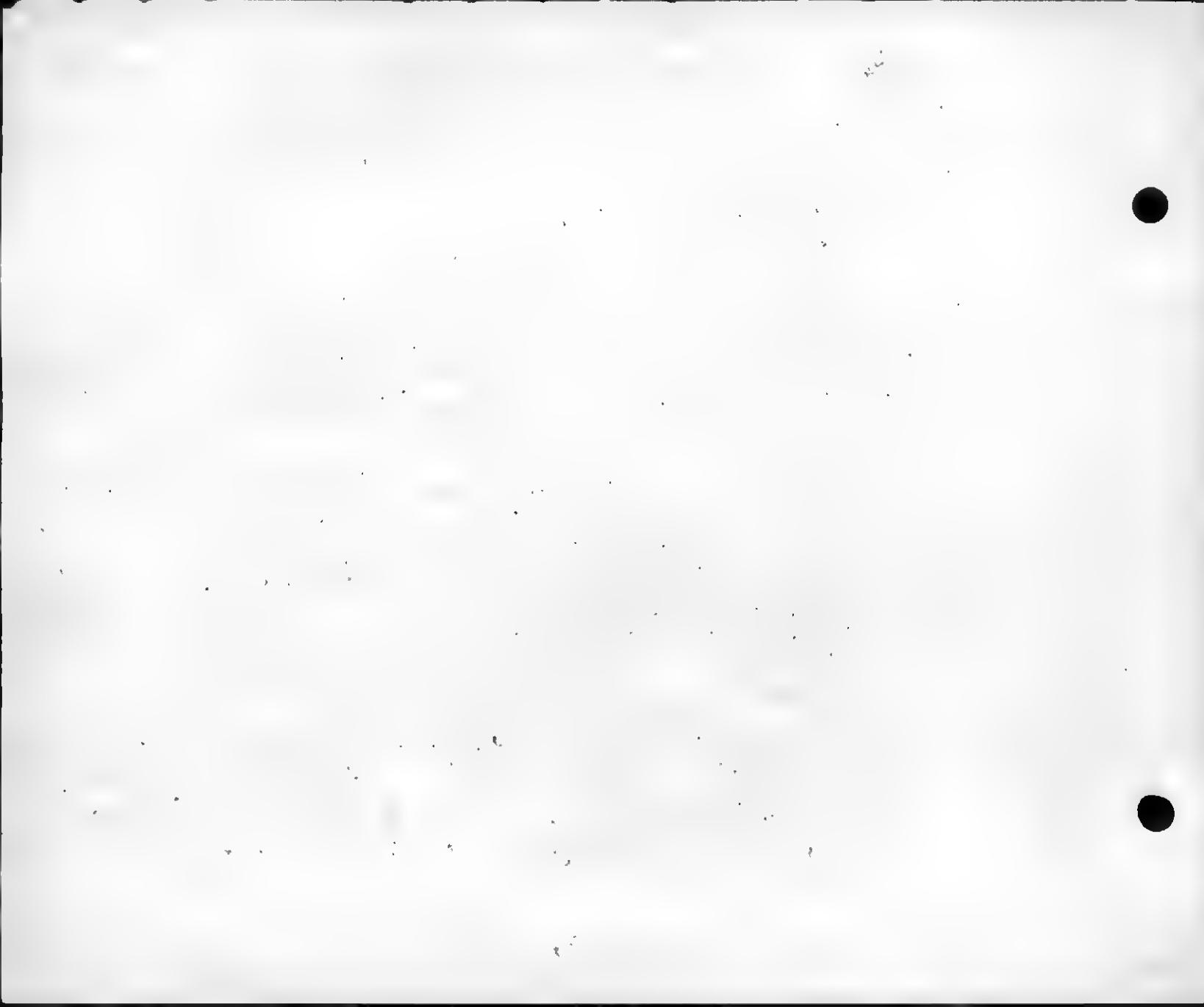
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10723 19716									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) John B. Parsons Home For The Aged					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rehoboth d. STREET ADDRESS Bay Vista e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EDNA POWERS			4. DATE OF DEATH July 22 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1888		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Delaware			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ulysis Melson					14. MOTHER'S MAIDEN NAME Eliza Carmine				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 4-222-292-18-8099		17. INFORMANT Address Lucy Powers, Rehoboth, Del.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency 4222 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 22 19 66 to 7-26 19 66 , that (I) (we) last saw the deceased alive on 7-22 19 66 and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE Dr. William B. Smith M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 7-25-66				
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith					22d. ADDRESS Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-25-66		23c. NAME OF CEMETERY OR CREMATORIAL St. Stephens Cemetery		23d. LOCATION (City, town or county) (State) Delmar, Del.			
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.					25a. REC'D BY REGISTRAR AUG 1 1966 25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1D <u>SALESBURY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLENDALE</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>KATH RINE E PRETTYMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1966</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-1897</u>		9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>WALTER P McCABE</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH K COLLINS</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>221-24-3239</u>		17. INFORMANT <u>ELSIE BUNTING</u>		Address <u>SALISBURY MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4X11</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerosis of Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>10 hrs</u> <u>10 hrs</u>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1965</u> to <u>July 1966</u> , that (I) (we) last saw the deceased alive on <u>7/3 1966</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Refus S. GARDNER JR</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/3/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>REFUS S. GARDNER JR</u>		22d. ADDRESS <u>MEDICAL CENTER SALISBURY</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-6-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		23d. LOCATION (city, town or county) (State) <u>MILFORD DEL</u>					
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>J Charles Judge</u>		25b. REGISTRAR'S SIGNATURE					



CERTIFICATE OF DEATH

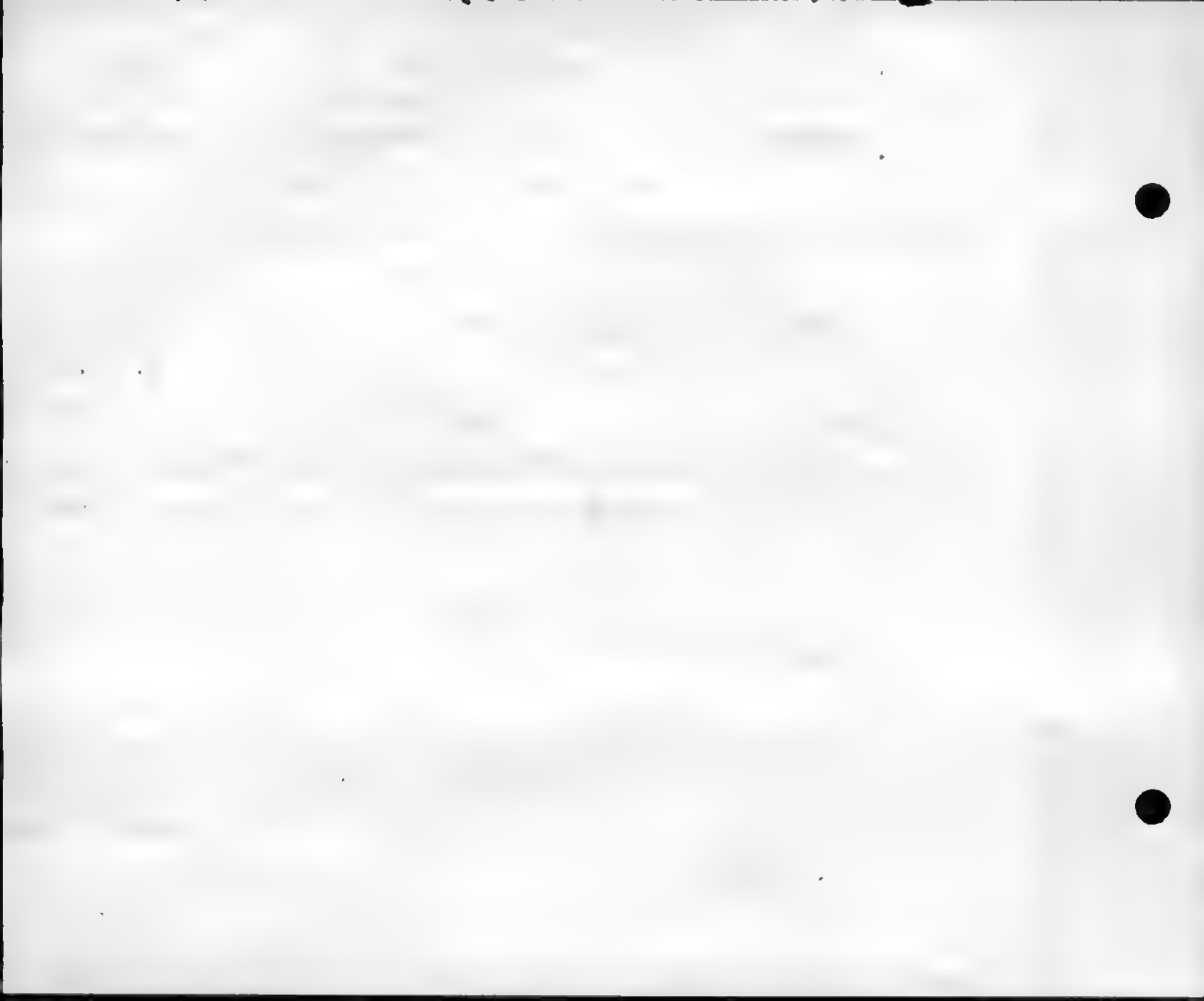
10718

10725

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b since 7/21/66	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		d. STREET ADDRESS 695 Fitzwater Street	
3 NAME OF DECEASED (Type or print) First Arthur Middle - Last Pruitt		4. DATE OF DEATH Month July Day 26 Year 19 66	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1900
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Separated	
11. BIRTHPLACE (County & State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bud Pruitt		14. MOTHER'S MAIDEN NAME Stella Pruitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 256-09-5041	
17. INFORMANT Mary E. Ellis		Address Records of Pine Bluff State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis			INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from July 21 , 19 66 , to July 26, 1966 , that he (we) last saw the deceased alive on July 26 , 19 66 , and that death occurred at 10:45 AM , from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED July 26, 1966	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-30-66	23c. NAME OF CEMETERY OR CREMATORY Wicomico Valley	23d. LOCATION (City or Town) (County) (State) Wicomico Va
24. FUNERAL DIRECTOR Booker M. White		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 3 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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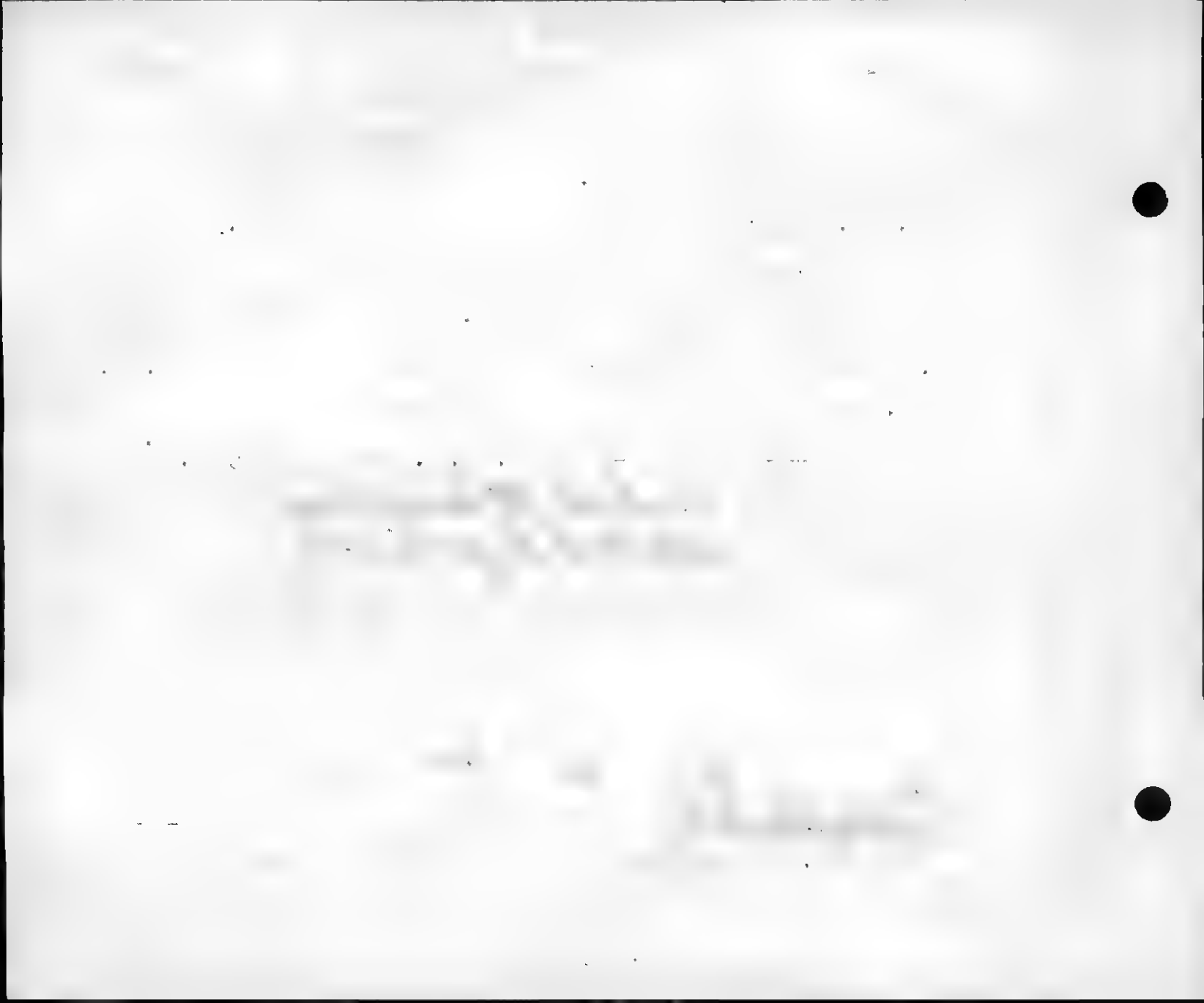
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10719

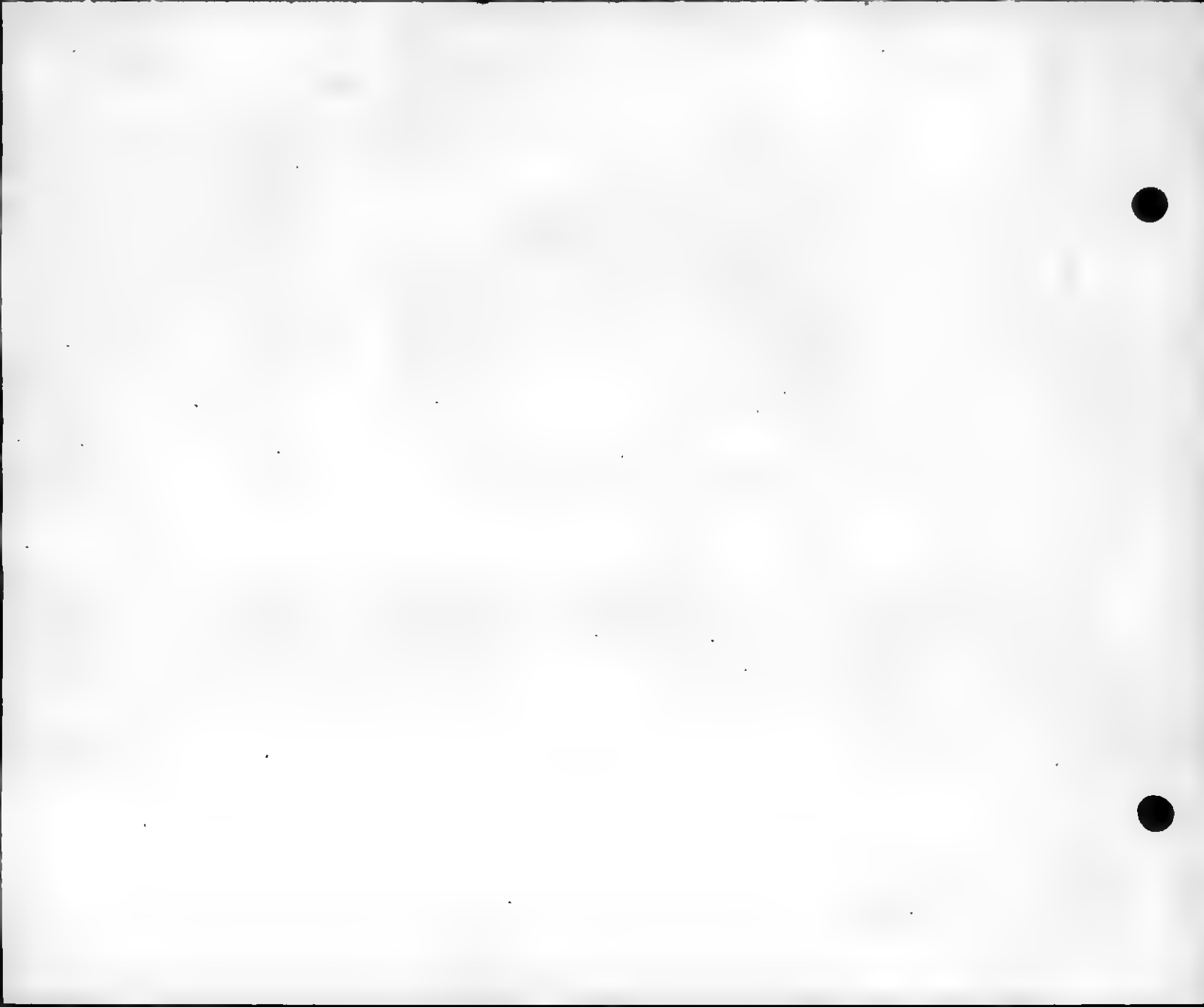
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		d. STREET ADDRESS 225 Shad Point Rd.,	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last PRYOR		4. DATE OF DEATH Month 7 Day 15 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1901
9. AGE (In years last birthday) yrs 64		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Seaman		10b. KIND OF BUSINESS OR INDUSTRY Oil Tanker	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Pryor		14. MOTHER'S MAIDEN NAME Ella Hobbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 181-05-1216	
17. INFORMANT Mr. Wm. E. Pryor		1257 Kerlin St., Chester, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral & hemorrhage DUE TO (b) essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN DEATH AND DEATH 1 day 2 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1965 to 7/15 1966 , that (I) (we) last saw the deceased alive on 7/15 1966 , and that death occurred at 6:21 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Earl Beardsley		22b. DATE SIGNED 7-18-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Earl Beardsley		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/18/1966	23c. NAME OF CEMETERY OR CREMATORY Union Church Cemetery	23d. LOCATION (City or Town) (County) (State) Wicomico County, Maryland
24. FUNERAL DIRECTOR Norman T. Baker Hill Funeral Home		25a. REC'D BY REGISTRAR DATE JUL 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The **death** certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN ID <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>SOMERSET</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>DEALS ISLAND</i>		d. STREET ADDRESS <i>Peninsula General Hospital</i>	
3. NAME OF DECEASED (Type or print) First <i>GEORGE</i> Middle <i>H.</i> Last <i>Richardson</i>		4. DATE OF DEATH Month <i>July</i> Day <i>13</i> Year <i>1966</i>		5. SEX <i>MALE</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAR. 24 1875</i>	
9. AGE (In years last birthday) <i>91</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BARBER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SELF EMP.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>BERLIN MD (W.D.)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <i>ANDREW RICHARDSON</i>		14. MOTHER'S MAIDEN NAME <i>ELEANOR POWELL</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>46-07-5902</i>		17. INFORMANT <i>MR. HARPER RICHARDSON, BERLIN MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ALL PNEUMONIA</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>4 DAYS</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>LEFT ATRIAL Atrial CARCINOMA</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>6/24</i> , 19 <i>66</i> , to <i>7/13</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/13</i> , 19 <i>66</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>D.M. Barker</i> 22c. PHYSICIAN'S NAME (Type)	
22b. DATE SIGNED <i>7/14/66</i>		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/14/66</i>		23c. NAME OF CEMETERY OR CREMATORY- <i>EVERGREEN</i>		23d. LOCATION (City, town or county) (State) <i>BERLIN MD</i>	
24. FUNERAL DIRECTOR <i>Anne A. Purchase Berlin Md</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 18 1966</i>		25b. REGISTRAR'S SIGNATURE <i>W. J. Judge</i>							



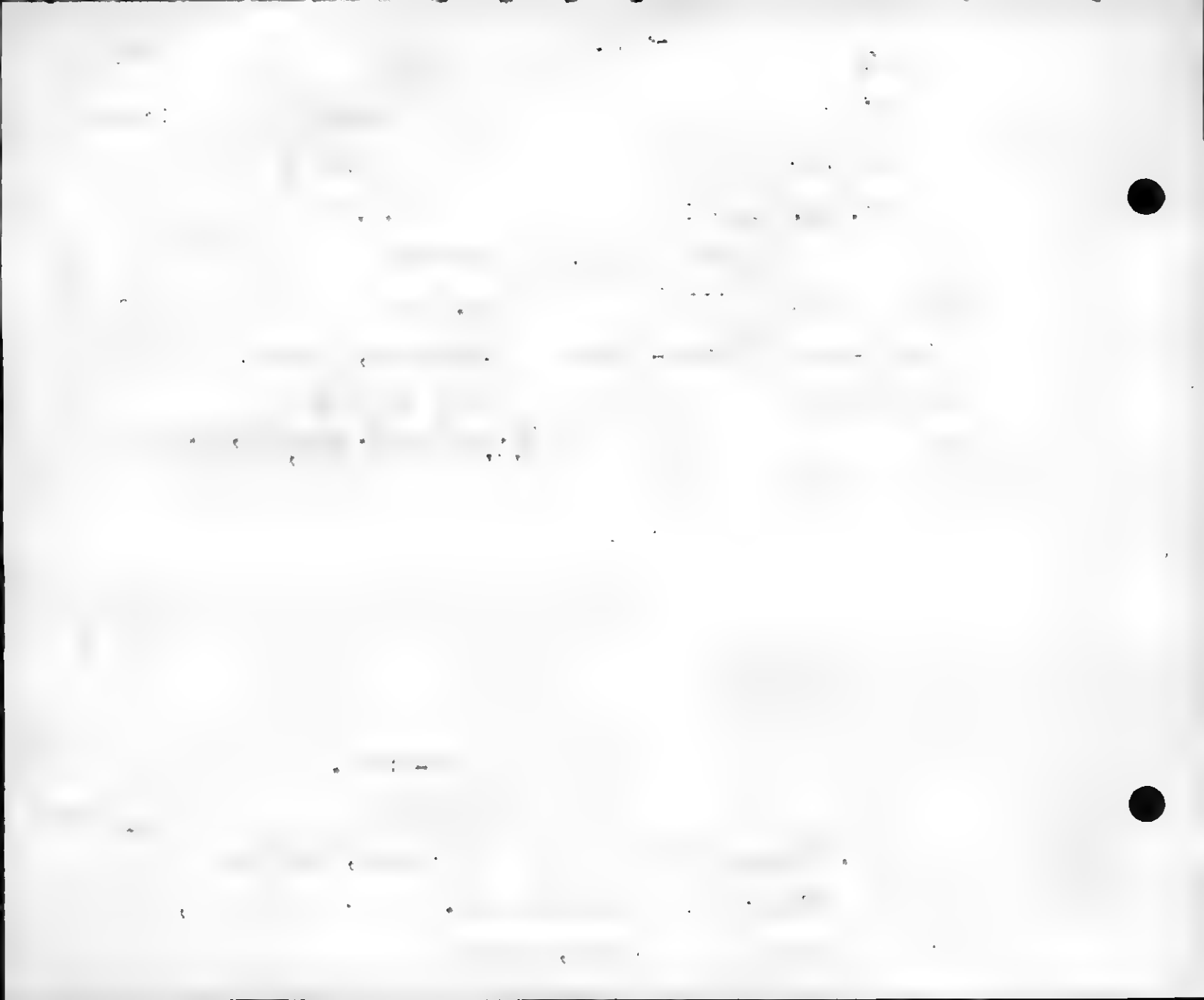
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10723											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury 22-1				d. STREET ADDRESS R.D.#2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen.Gen.Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) VIRGINIA CAROLYN SHOCKLEY						4. DATE OF DEATH JULY 14th 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb.23/1914		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 04 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Shirt Factory-Packer						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		
12. CITIZEN OF WHAT COUNTRY? U S A											
13. FATHER'S NAME Larry Collins						14. MOTHER'S MAIDEN NAME Clara LeCates					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Preston E. Shockley, Jr. (Husband) R.D.# 2 Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia. DUE TO (b) Plural effusion. DUE TO (c) Lymphatic obstruction by metastatic adenocarcinoma. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from April 6, 1966 to 7-14 , 19 66 , that (I) (we) last saw the deceased alive on 7-14 19 66 , and that death occurred at 20P M, from the causes and on the date stated above.											
22a. SIGNATURE Stedman W. Smith						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 15/1966			
22c. PHYSICIAN'S NAME (Type) Dr. Stedman Smith						22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 18/1966		23c. NAME OF CEMETERY OR CREMATORY Springhill Mem.Gardens				23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY						ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUL 18 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



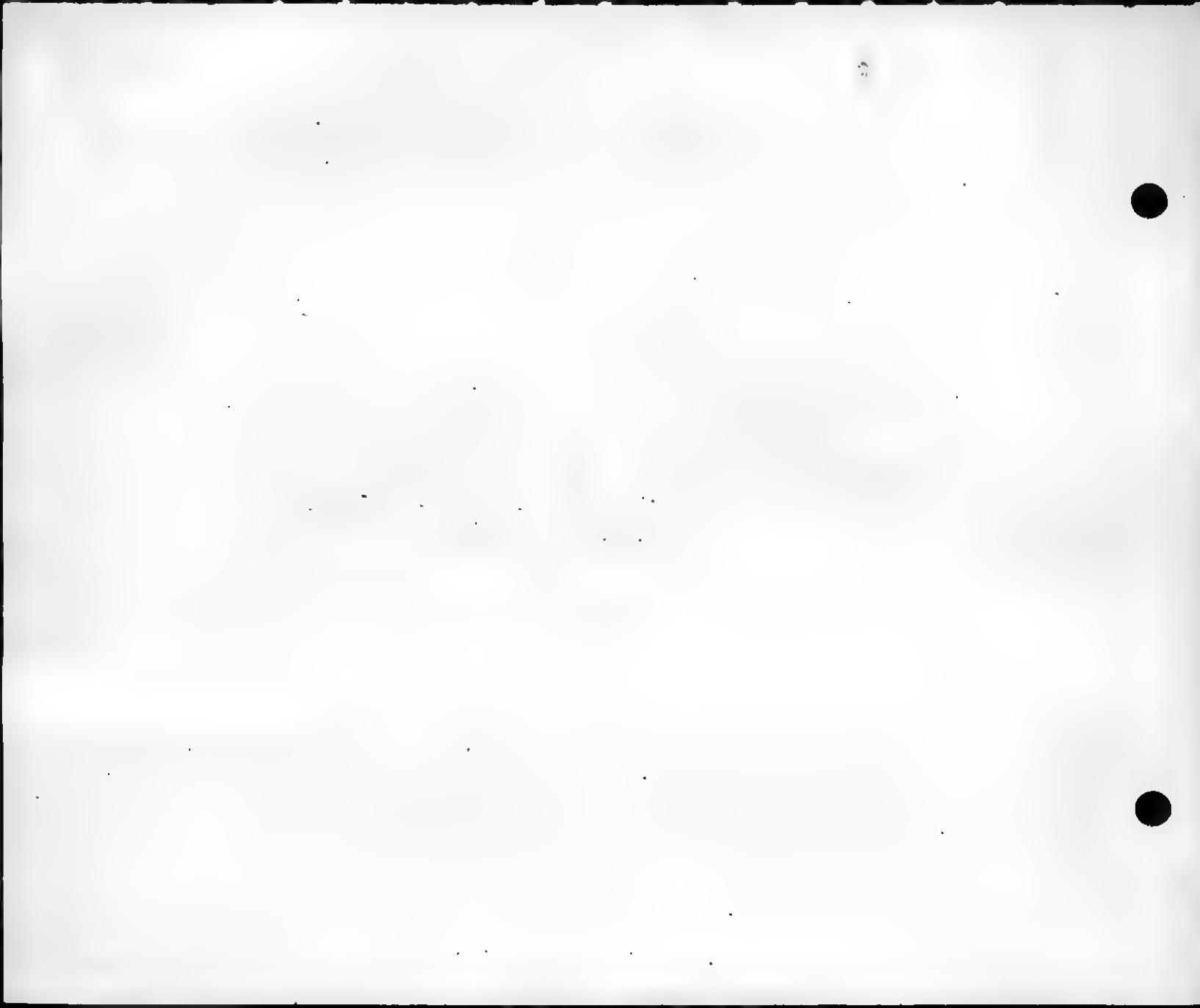
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

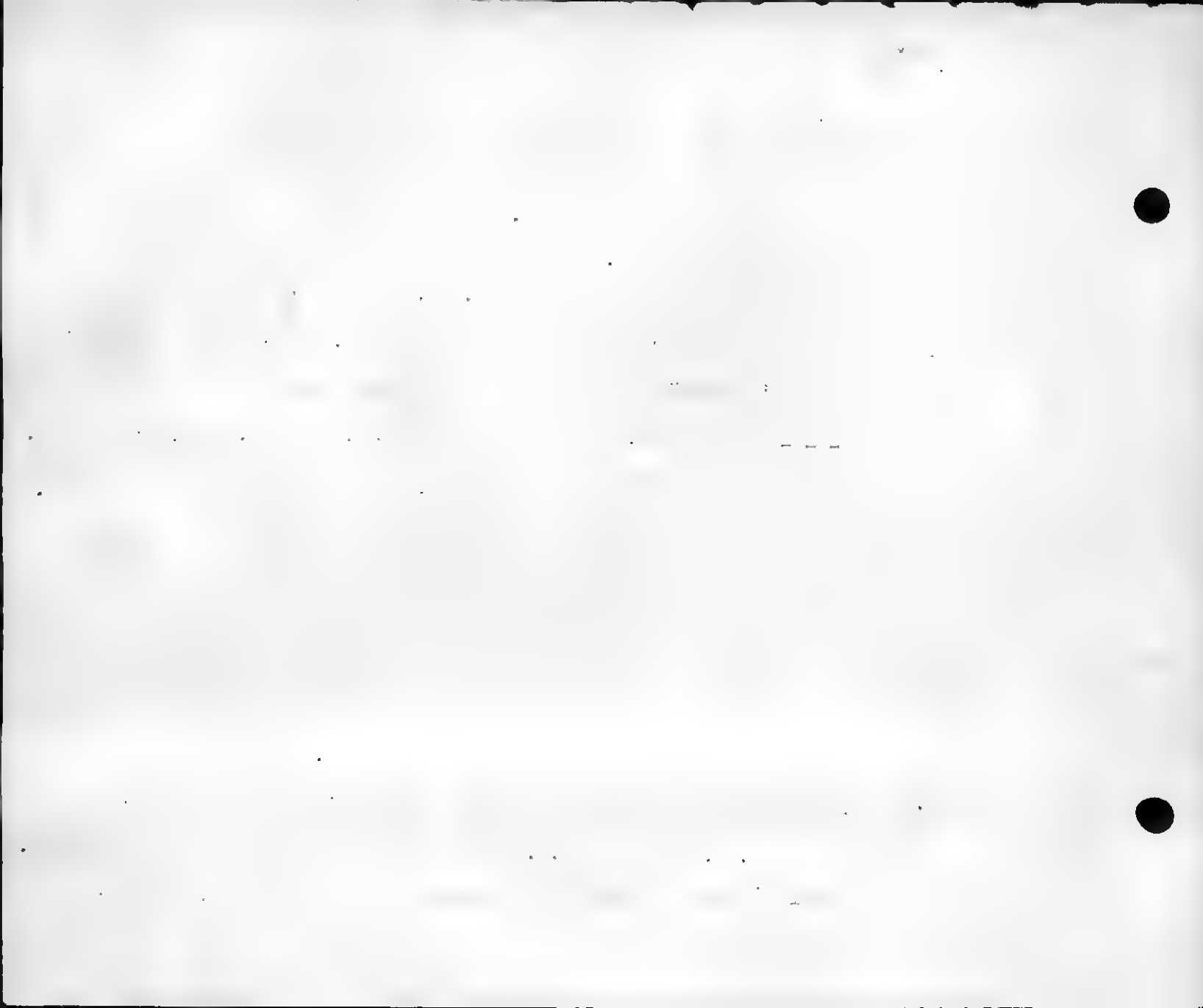
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>Selbyville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>Rt. 2 Box 197</i>	
3. NAME OF DECEASED (Type or print) <i>William Thomas Showell</i>		4. DATE OF DEATH <i>July 23 1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Delaware</i>	
13. FATHER'S NAME <i>Jacob Showell</i>		14. MOTHER'S MAIDEN NAME <i>Glenn Harmon</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic abscesses</i> 785X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Cholangitis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i> n	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Anemia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>7/19 66</i> to <i>7/23 66</i> , that (I) (we) last saw the deceased alive on <i>7/23 1966</i> , and that death occurred at <i>4:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul J. Harmon</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<i>Burial</i>	<i>7-28-66</i>	<i>Whaleville Church Cem.</i>	<i>Whaleville, Md</i>
24. FUNERAL DIRECTOR <i>Loretta D. J. My. Jansky Rd. Sales</i>		25a. REC'D BY REGISTRAR <i>Charles J. Jansky</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jansky</i>	
		DATE <i>AUG 1 1966</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1621</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>People's Real State Hospital, Salisbury, Md.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hoopersville</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cliver J. Simmons</u>						4. DATE OF DEATH Month Day Year <u>7 23 1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1889</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>George Simmons</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Insley</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs Elizabeth R. Simmons, Hoopersville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident, recurrent</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis Cardiovascular Disease</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12/5, 1961</u> to <u>7/23, 1966</u>, that (I) (we) last saw the deceased alive on <u>7/23, 1966</u>, and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED <u>7/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>A. J. Mitchell, D.O.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Jul 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland</u>			
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service, Cambridge, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>JUL 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



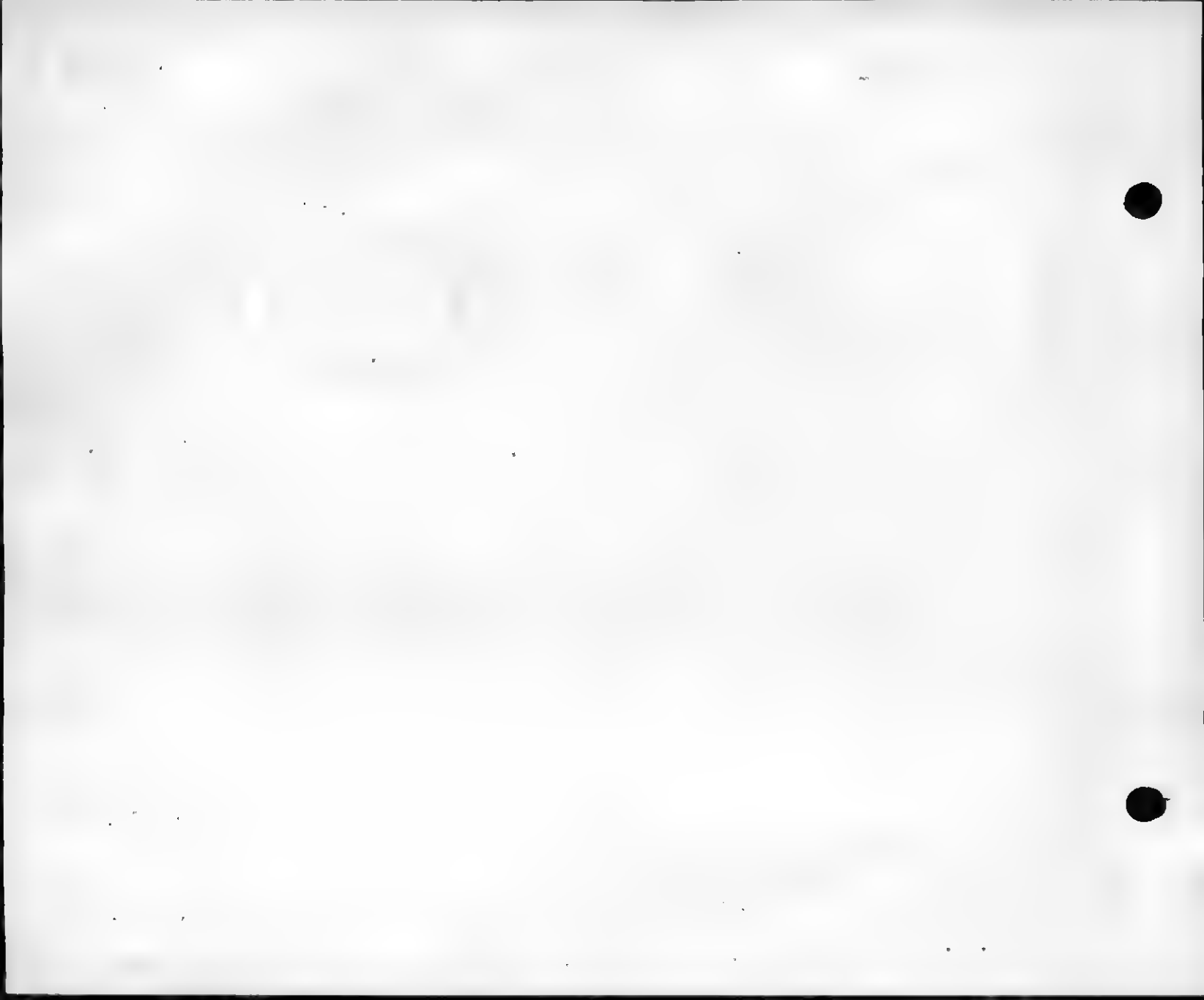
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MARYLAND STATE DEPARTMENT OF HEALTH

10724

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs - Rural		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) San Domingo		d. STREET ADDRESS San Domingo		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blonnie		Middle Harriet		Last Smiley	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 8, 1900		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Sussex Co., Delaware	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Hoverton		14. MOTHER'S MAIDEN NAME Jannie Deshield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT J. Milton Smiley, Mardela Springs, Md., RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 DUE TO Heart failure DUE TO Seeds only		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1966 , 19 1966 , that (I) (we) last saw the deceased alive on July 18, 1966 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Frederick D. Quinn		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 18, 1966	
22c. PHYSICIAN'S NAME (Type) Frederick D. Quinn		22d. ADDRESS Mardela Springs, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery	
23d. LOCATION (City, town or county) Near Sharptown, Maryland		(State)			
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JUL 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10732

CERTIFICATE OF DEATH

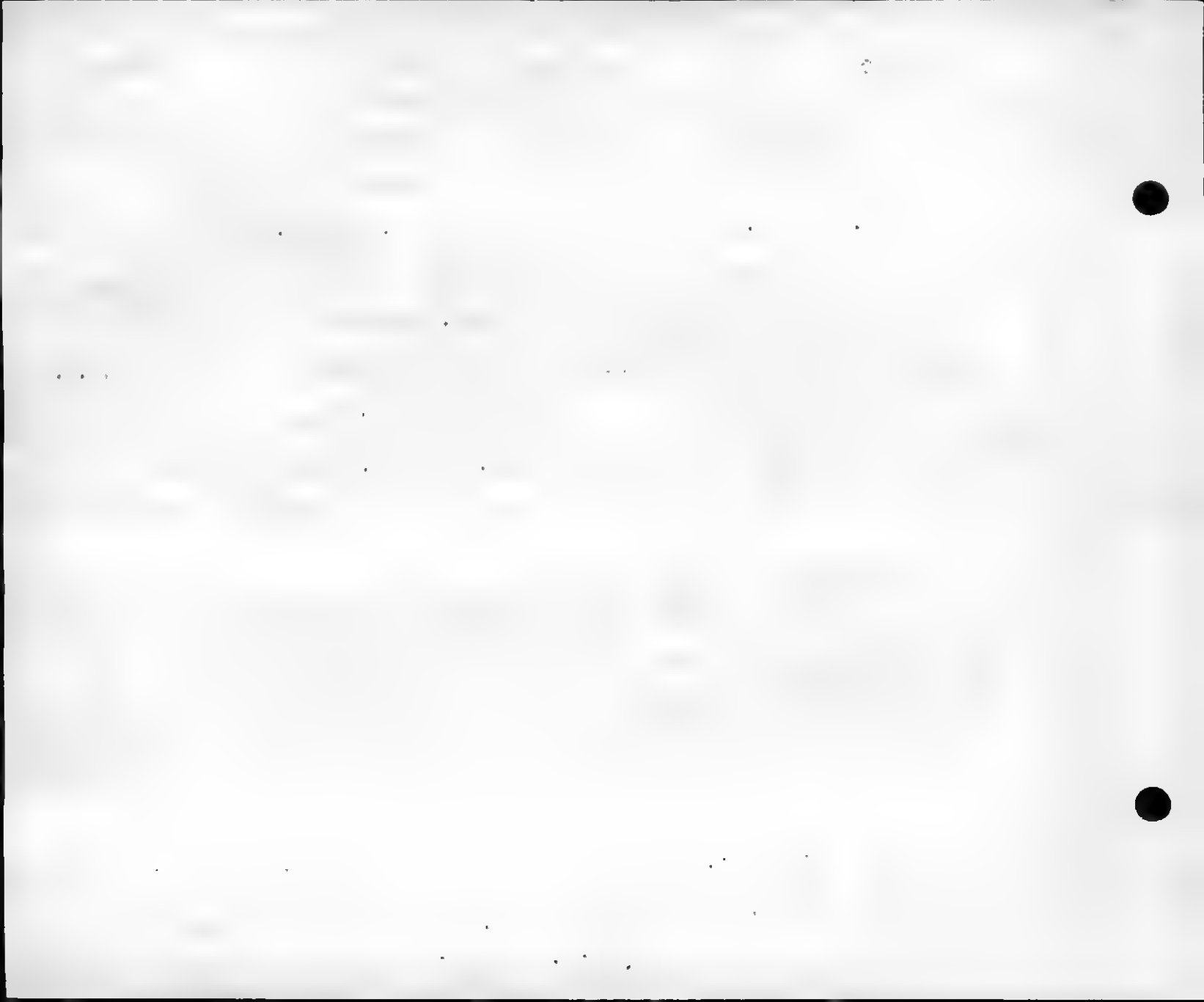
10725

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admittance) a. STATE MARYLAND b. COUNTY WICOMICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRUITLAND			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRUITLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E. MAIN ST.,				d. STREET ADDRESS E. MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS SMITH				4. DATE OF DEATH Month Day Year JULY 11 1966			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 20, 1880	
9. AGE (In years last birthday) 85 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS SMITH			
14. MOTHER'S MAIDEN NAME JULIA JONES				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****			
16. SOCIAL SECURITY NO.				17. INFORMANT MRS. THOMAS J. SMITH SEE 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Atherosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 7-11-1966 to 7-11-1966 that (I) (we) last saw the deceased alive on 7-11-1966 and that death occurred at 7-11-1966 M, from causes and on the date stated above.			
22a. SIGNATURE WILBER R. ELLIS, JR.				22b. DATE SIGNED 7-13-66		22c. PHYSICIAN'S NAME (Type) WILBER R. ELLIS, JR MD	
22d. ADDRESS MEDICAL CENTER, SALISBURY, MARYLAND				23a. REC'D BY REGISTRAR DATE JUL 15 1966			
23b. REGISTRAR'S SIGNATURE Charles Jones				23c. NAME OF CEMETERY OR CREMATORY WICOMICO MEM. PARK			
23d. LOCATION (City or Town) (County) (State) SALISBURY, MARYLAND				23e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
23f. DATE THEREOF 7/13/1966				23g. NAME OF CEMETERY OR CREMATORY WICOMICO MEM. PARK			
23h. LOCATION (City or Town) (County) (State) SALISBURY, MARYLAND				23i. FUNERAL DIRECTOR Harold H. H. H.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10733

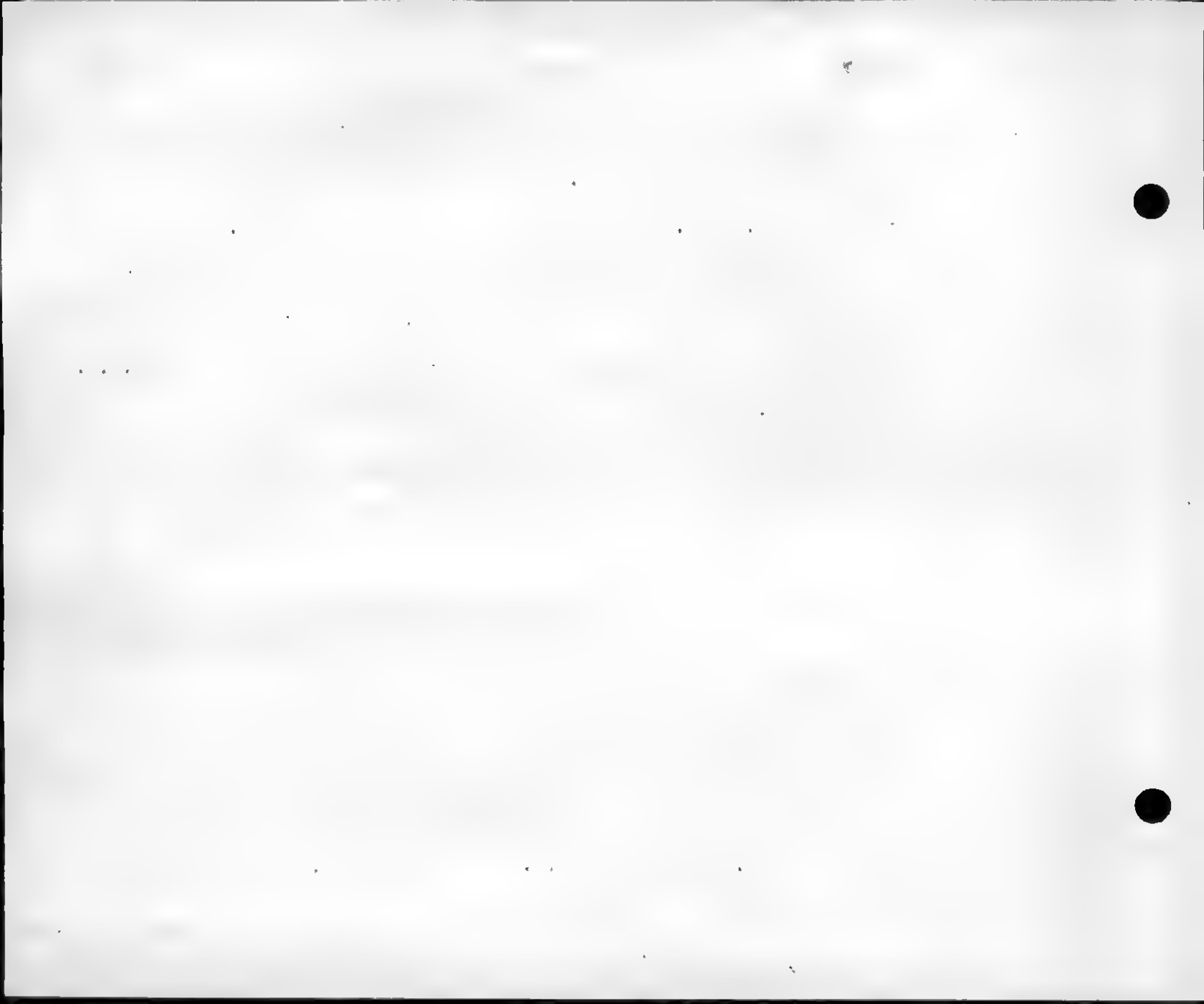
CERTIFICATE OF DEATH

10726

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING HILL PR. SANI.		e. STREET ADDRESS 725 CAMDEN AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLOTTE COLLINS TAYLOR		4. DATE OF DEATH Month Day Year JULY 14 1966	
5. SEX female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1904
9. AGE (in years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROLLIN P. COLLINS		14. MOTHER'S MAIDEN NAME NELLIE CANNON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT SETH C. TAYLOR Address SEE 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: metastatic CA 170X IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.A. left breast (c) 3 years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-5 , 19 65 , to 7-14 , 19 66 , that (I) (we) last saw the deceased alive on 7-13 , 19 66 , and that death occurred at 3 A M, from causes and on the date stated above.			
22a. SIGNATURE Earl L. Royer		22b. DATE SIGNED 7-14-66	
22c. PHYSICIAN'S NAME (Type) EARL L. ROYER M.D.		22d. ADDRESS CAMDEN AVE., SALISBURY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL OF BODY BURIAL	23b. DATE THEREOF 7/16/1966	23c. NAME OF CEMETERY OR CREMATORY ODDFELLOW'S CEMETERY	23d. LOCATION (City or Town) (County) (State) BISHOPVILLE
24. FUNERAL DIRECTOR George C. Hays ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JUL 20 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

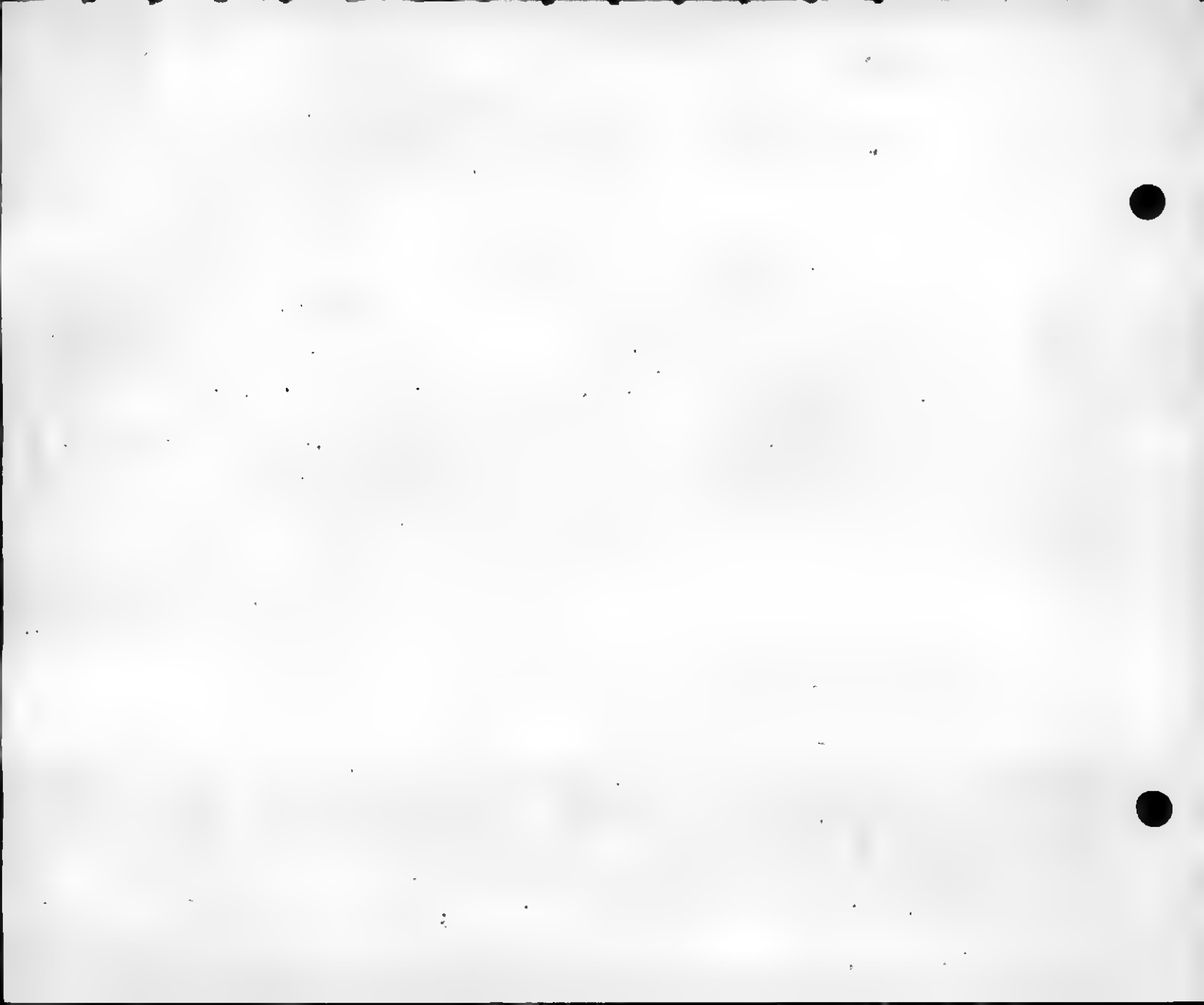
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WENONA d. STREET ADDRESS MAIN ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORRIS Middle TAYLOR Last TAYLOR 4. DATE OF DEATH Month JULY Day 14 Year 1966		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JAN 21 - 1915 9. AGE (in years last birthday) 51 yrs. IF UNDER 1 YEAR: Months 1 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN 10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BRINKLEY 14. MOTHER'S MAIDEN NAME LULY WILSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes W.W.II 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT Mrs. Elizabeth Taylor Wenona Md Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6-21, 1966 to 7-14, 1966 that (I/we) last saw the deceased alive on 7-14, 1966 and that death occurred at 7:30 AM from the causes and on the date stated above.	
22a. SIGNATURE Wesley R. [Signature] 22c. PHYSICIAN'S NAME (Type) Wesley R. [Signature] 22d. ADDRESS [Signature] 22e. DATE SIGNED 7-14-66 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 7-17-1966 23c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY 23d. LOCATION (City, town or county) (State) WENONA MD 24. FUNERAL DIRECTOR L. G. Webster Princess Anne 25a. REC'D BY REGISTRAR [Signature] 25b. REGISTRAR'S SIGNATURE [Signature] DATE JUL 19 1966	

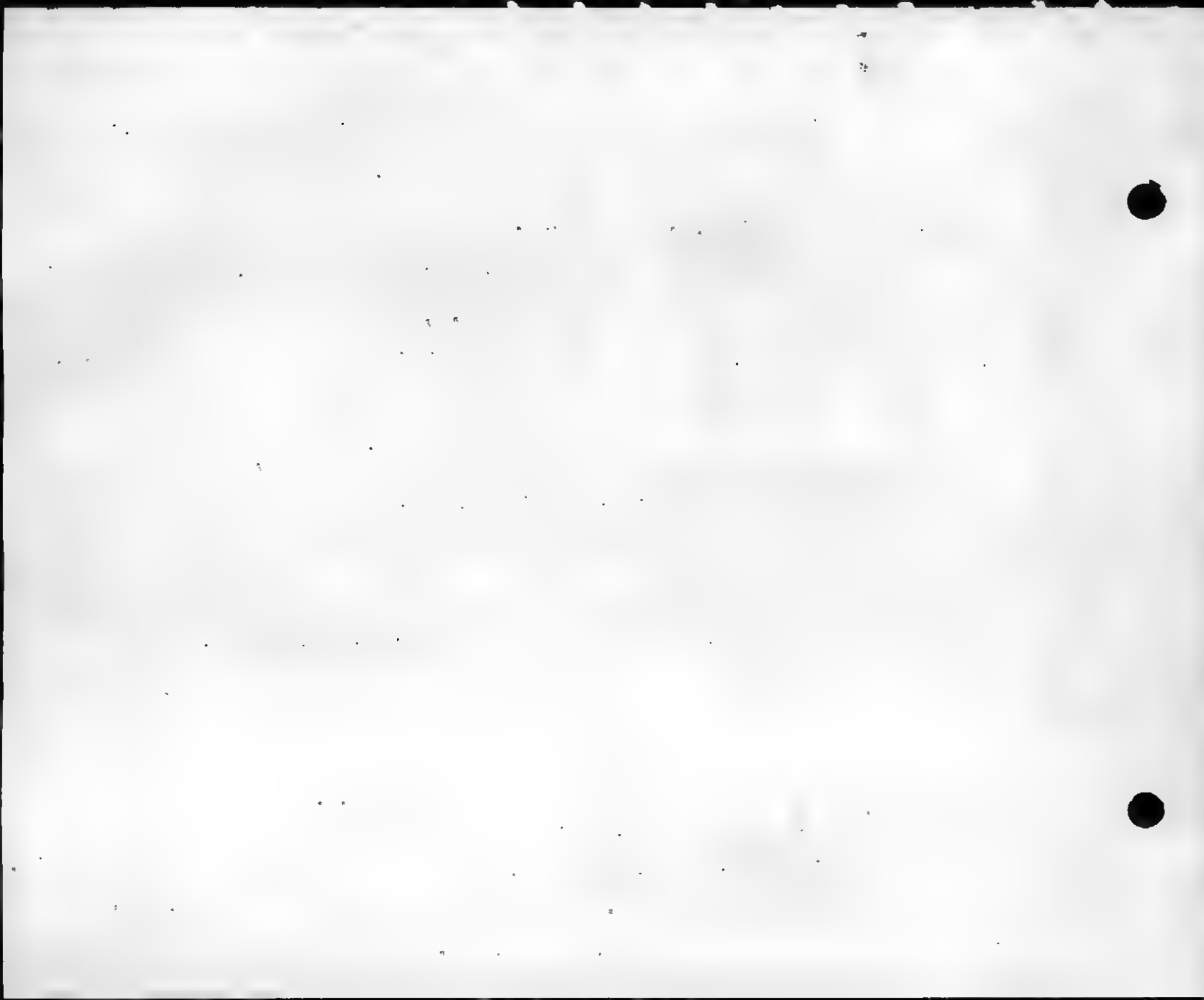


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																																	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN ID <u>79 Days</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Fairmount</u>																												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>					d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																												
3. NAME OF DECEASED First <u>Reuben</u> Middle <u>Rathbun</u> Last <u>Townroe</u>			4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1966</u>																														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="4">IF UNDER 1 YEAR</th> <th colspan="4">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR				IF UNDER 24 HRS.				Months	Days	Hours	Min.	Months	Days	Hours	Min.								
IF UNDER 1 YEAR				IF UNDER 24 HRS.																													
Months	Days	Hours	Min.	Months	Days	Hours	Min.																										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Engineer</u>					10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>																										
13. FATHER'S NAME <u>Frederick Townroe</u>					14. MOTHER'S MAIDEN NAME <u>Rose Rathbun</u>																												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.																												
					17. INFORMANT <u>John Townroe</u> <u>4101 San Jacinto</u> <u>Houston, Texas</u>																												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> 443X DUE TO (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hours</u> Years																									
PART II. OTHER SIGNIFICANT CONDIIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIION GIVEN IN PART I (a) <u>Diabetes mellitus; Ca of large bowel with resection - colostomy.</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																									
21. I certify that (I) (this hospital) attended the deceased from <u>4/26</u>, 19<u>66</u>, to <u>7/14</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>7/11</u>, 19<u>66</u>, and that death occurred at <u>12:20</u>, from the causes and on the date stated above.																																	
22a. SIGNATURE <u>Charles H. Minnacott</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/14/66</u>																										
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Minnacott, M.D.</u>					22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>																												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>7/17/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews</u>		23d. LOCATION (City, town or county) (State) <u>Princess Anne, Md.</u>																										
24. FUNERAL DIRECTOR <u>James Shuman</u>					ADDRESS <u>Princess Anne, Md.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>J. Davis</u>																										
					DATE <u>JUL 19 1966</u>																												

20M



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and on day of event within 72 hours after death.

VR A15ME
6M 1/66

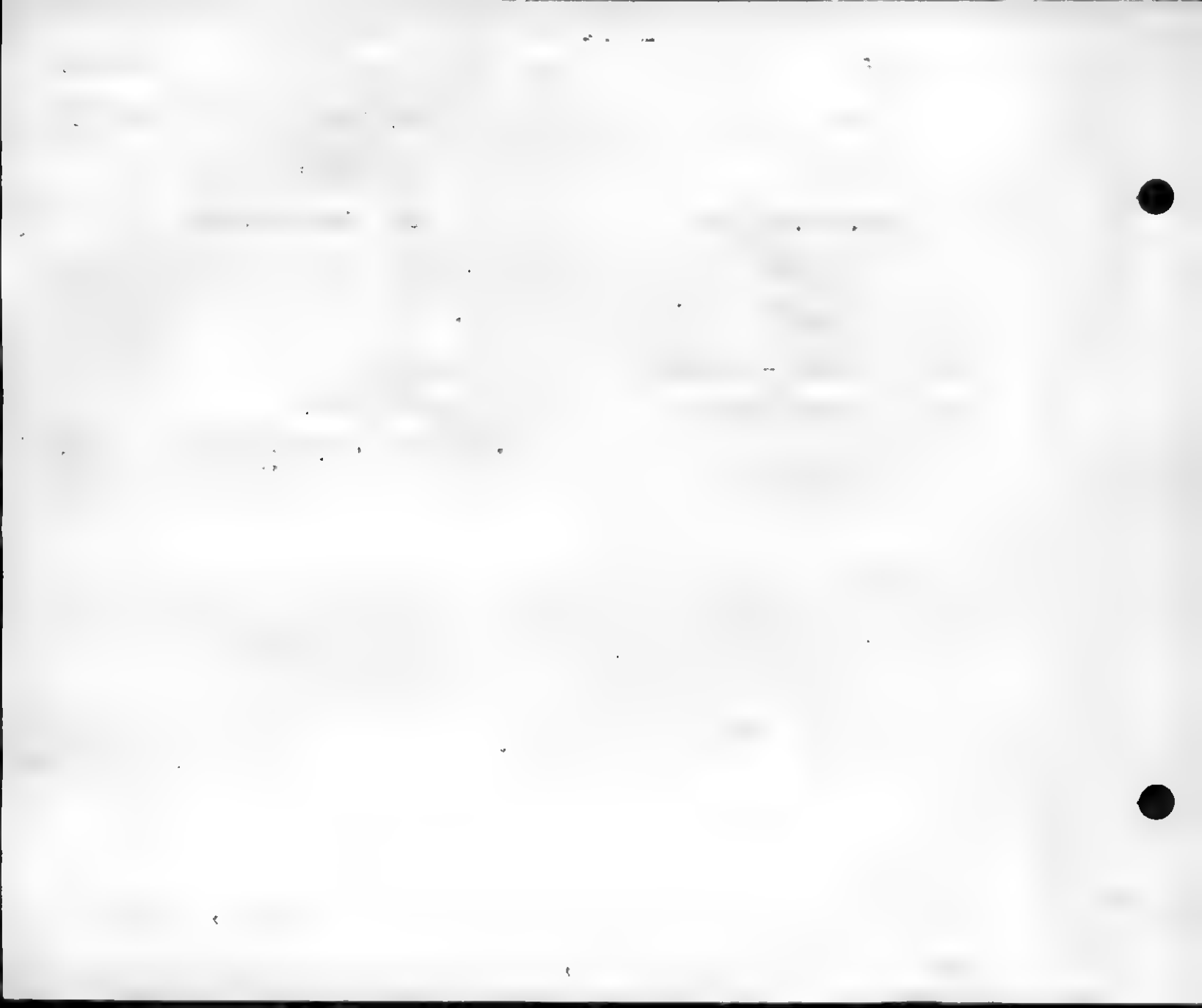
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10729

1. PLACE OF DEATH a COUNTY Wicomico b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c LENGTH OF STAY IN 1b Salisbury		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Wicomico c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		e STREET ADDRESS 197 Pierce Avenue f RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last TRADER		4. DATE OF DEATH Month JULY Day 7th Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2/1892
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 9 Days 5 Hours 5 Min 0	
10a. USUAL OCC. PAT. ON (Give kind of work done during most of working life, even if retired) Retired clerk - Clothing Store		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jesse Overton Bernard		14. MOTHER'S MAIDEN NAME Annie Crawford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Stanley V. Trader (Husband) 107Pierce Avenue Salisbury, Maryland 21801	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) X DUE TO (c) X			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - Fracture femur - arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH X		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Slipped + fell at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/30 p.m. 19 66		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) Home
20f. (City or town) (County) (State) Salisbury Md		21. I certify that took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Philip A. Instey M.D. EXAMINER'S NAME (Type) Philip A. Instey		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 7-8-66		23a. BURIAL CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF July 9/1966		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
23d. LOCATION (City or town) (County) (State) Salisbury, Maryland		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR JUL 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2621 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>802 Delaware Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Harrison</u> Last <u>Whaley</u>			4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 66</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-1898</u>		9. AGE (In years last birthday) <u>68 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Washington Whaley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Noden</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pres. Joseph Whaley</u> Address <u>#3 Lake St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, left lower lobe, marked</u> DUE TO (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 19</u> , 19 <u>59</u> to <u>July 22</u> , 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>July 22</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Andrew C. Mitchell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7/25/66</u>		8:10 P.M.	
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>				22d. ADDRESS <u>Deer's Head State Hospital; Salisbury, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenview</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Md.</u>			
24. FUNERAL DIRECTOR <u>Loretta B. Jolley-Jeremy R. #42 Salis.</u>				25a. REC'D BY REGISTRAR <u>Charles J. J.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>			
				DATE <u>AUG 1 1966</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Life time d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution, give address before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last ERNEST LINWOOD WHITE		4 DATE OF DEATH Month Day Year July 9 19 66	
5 SEX Male	6 COLOR OR RACE Col.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/9/27
9 AGE (in years last birthday) 38		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Salesman		10b KIND OF BUSINESS OR INDUSTRY Auto	
11 BIRTHPLACE (State or foreign country) Somerset County Md		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Ernest Linwood White Sr		14 MOTHER'S MAIDEN NAME Harriett Ballard	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW II		16 SOCIAL SECURITY NO 17 INFORMANT Ernest L White Sr. Westover, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exsanguination from gunshot wounds of both upper legs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Walked in tavern - was shot in both legs with		INTERVAL BETWEEN ONSET AND DEATH 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20c TIME OF INJURY Month, Day, Year 10:20 p.m. 7/9 19 66		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d INJURY OCCURRED While <input type="checkbox"/> or work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Stetons Tavern Princess Anne Som. Md.	
20f (City or town) (County) shotgun		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Philip A. Insley</i> EXAMINER'S NAME (Type) Philip A. Insley		22. DATE SIGNED 7/18/66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town) 1108 Main St., Salisbury	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/16/66	23c NAME OF CEMETERY OR CREMATORY John Wesley	23d LOCATION (City or town) (County) (State) Cottage Grove, Md.
24 FUNERAL DIRECTOR William H. James Jr, Princess Anne, Md		25a REC'D BY REGISTRAR JUL 21 1966	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

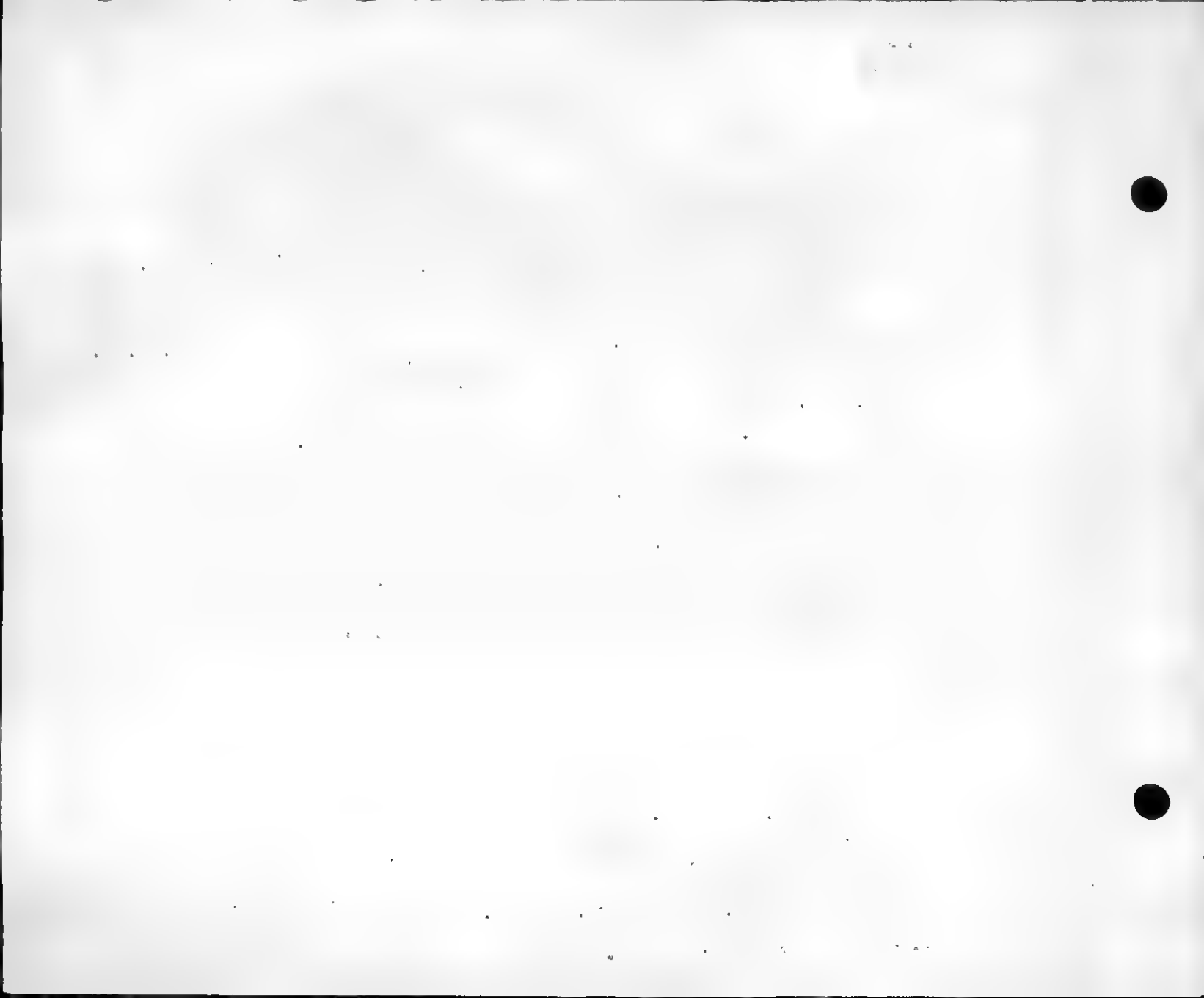


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wallops Road</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>William Willis Williams</u> First Middle Last				4. DATE OF DEATH <u>July 23 1966</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 13 1906</u> 9. AGE (in years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR <u>23</u> Months <u>2</u> Days <u>19</u> Hours <u>66</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John A. Williams</u> 14. MOTHER'S MAIDEN NAME <u>Laura Collins</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>230-07-0709</u> 17. INFORMANT <u>Evelyn Williams Wallops, Virginia</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic cirrhosis & liver failure</u> (b) <u>10</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic glomerulonephritis & renal insufficiency</u>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>7-18-1966</u>, to <u>7-23-1966</u>, that (I) (we) last saw the deceased alive on <u>7-23 1966</u>, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>James L. Clifford</u> 22b. DATE SIGNED <u>7/23/66</u> 22c. PHYSICIAN'S NAME (Type) <u>James L. Clifford</u> 22d. ADDRESS <u>MEDICAL CENTER SALISBURY MD</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>July 26, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Oak Hall Virginia</u> 24. FUNERAL DIRECTOR <u>Salzer Funeral Home, Chincoteague, Virginia</u> 25a. REC'D BY REGISTRAR <u>JUL 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>													



CERTIFICATE OF DEATH

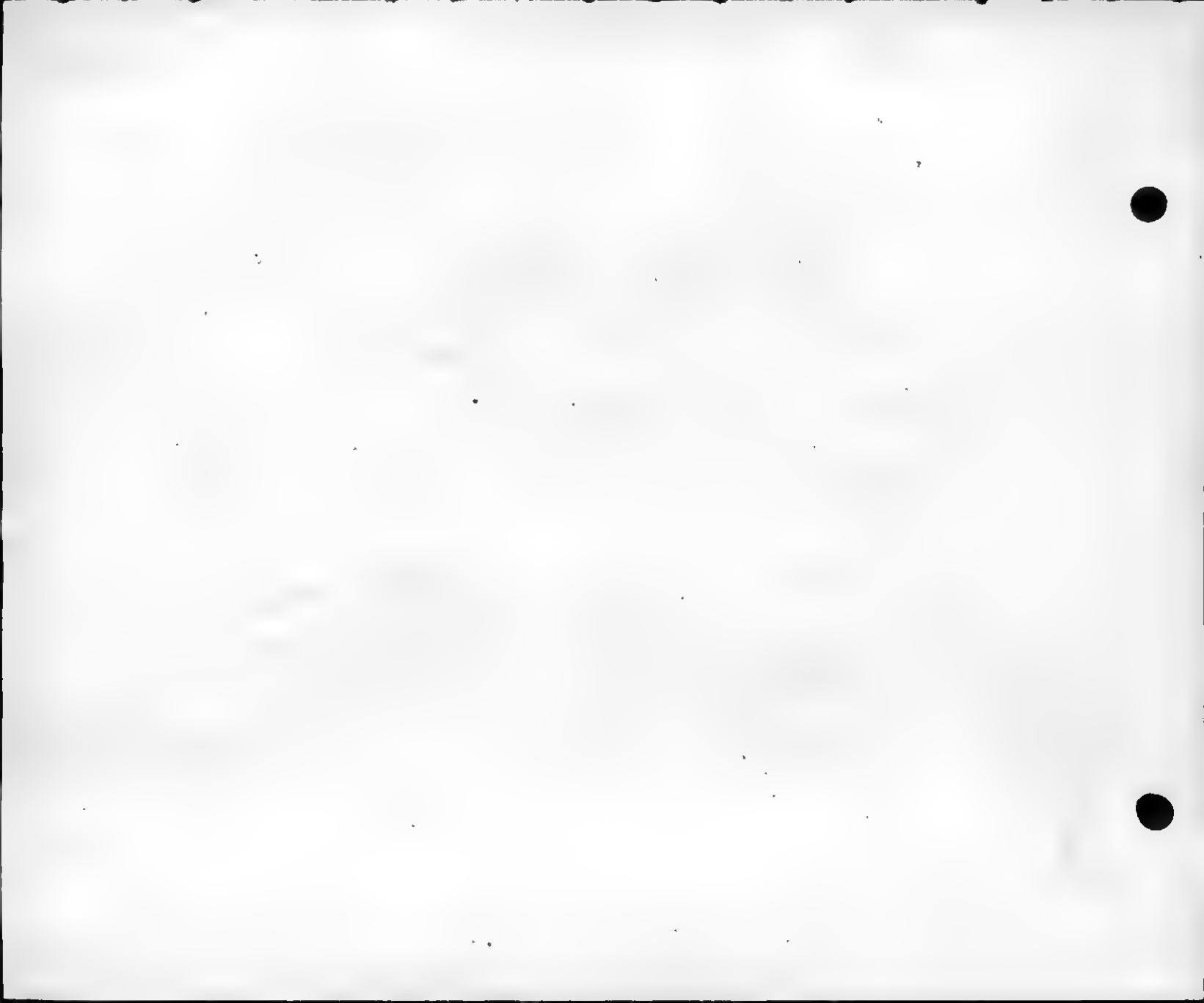
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1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>Parker Ave R3</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Attalee Wright</u>				4. DATE OF DEATH <u>July 1 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-1908</u>	
9. AGE (in years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>DELMAR-MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CLARENCE TINGLE</u>				14. MOTHER'S MAIDEN NAME <u>MIKKIE BRITTINGHAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NC</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>221-07-2309</u>			
17. INFORMANT <u>ROY WRIGHT-SALISBURY MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordiac Failure</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno Carcinoma of Uterus with</u>							
(c) <u>generalized metastasis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>66</u> , to <u>7/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> , 19 <u>66</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>William J. Dornick</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/6/66</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-3-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MELSON</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR-MD</u>	
24. FUNERAL DIRECTOR <u>Charles W. Garmel - Delmar, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>JUL 5 1966</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 804 Spring Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 804 Spring Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle DELPHIN Last WYNN				4. DATE OF DEATH Month JULY Day 21 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19/1908	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 9 Days 2 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager- Liq. Petro. Ind.		11. BIRTHPLACE (County & State, or foreign country) Oklahoma	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME John David Wynn			
14. MOTHER'S MAIDEN NAME Delphia Ehrhardt				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 442-07-8800				17. INFORMANT Mrs. Ruth S. Wynn (Wife) Address 804 Spring Ave. Salisbury, Maryland 21801			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4201 DUE TO (b) Embolism, probably from heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Obstructive Airway Disease						INTERVAL BETWEEN ONSET AND DEATH 20 hrs.	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/21 , 19 66 , to 7/21 , 19 66 , that (I) (we) last saw the deceased alive on 7/21 , 19 66 , and that death occurred at 11:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Rufus S. Gardner Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 23/1966	
22c. PHYSICIAN'S NAME (Type) DR. Rufus S. Gardner Jr.				22d. ADDRESS Pine Bluff Road Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25/66		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR JUL 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 6 mo. 28 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital						e. STREET ADDRESS			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ernest			First Middle Last Younger			4. DATE OF DEATH July 17 19 66			Month Day Year		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1886		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Daniel P. Younger						14. MOTHER'S MAIDEN NAME Elizabeth DeFord					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214 12 6055 A		17. INFORMANT Ethel Jennings Address Sudlersville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease (c) Chronic pulmonary emphysema										INTERVAL BETWEEN ONSET AND DEATH 24 hrs yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 20, 1965 to July 17, 1966 , that (I) (we) last saw the deceased alive on July 17, 1966 , and that death occurred at 12:10 AM from the causes and on the date stated above.											
22a. SIGNATURE L. Maldve						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 7-17-66		
22c. PHYSICIAN'S NAME (Type) L. Maldve, M.D.						22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/20, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.			23d. LOCATION (City, town or county) (State) near Rock Hall Chestertown, Md			
24. FUNERAL DIRECTOR J. Willis Wells						ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR JUL 19 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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